DOCUMENT RESUME

ED 460 320 CG 031 068

TITLE	AusEinetter, 1998.
INSTITUTION	Australian Early Intervention Network for Mental Health in Young People, Bedford Park, South Australia.
SPONS AGENCY	Australian Commonwealth Dept. of Health and Family Services, Canberra.
ISSN	ISSN-1329-8720
PUB DATE	1998-00-00
NOTE	53p.; Five issues were produced in 1998. For the 1997 series, see ED 444 038.
AVAILABLE FROM	Australian Early Intervention Network for Mental Health in Young People, C/- CAMHS Southern, Flinders Medical Center, Bedford Park, South Australia 5042. For full text: http://auseinet.flinders.edu.au.
PUB TYPE	Collected Works - Serials (022)
JOURNAL CIT	AusEinetter; n3-7 1998
EDRS PRICE	MF01/PC03 Plus Postage.
DESCRIPTORS	*Adolescents; Children; Foreign Countries; *Intervention; *Mental Health; National Programs; *Prevention; Programs; Suicide
IDENTIFIERS	Australia

ABSTRACT

This publication contains the 1998 issues of the Australian Early Intervention Network for Mental Health in Young People newsletters for health professionals. The newsletters disseminate information about the national and local initiatives for intervention and prevention of mental health problems in young children and youth. Each issue also offers news items on upcoming forums, workshops, or support groups; information on health topics; and reports from start-up operations of new programs. Guest articles in these issues include: "Early Intervention in Youth Suicide in Australia"; "Future Pathways for Prevention and Early Intervention: 'Prevention for the Nineties'" (Patrick McCorry); "Early Intervention for Attention-Deficit Hyperactivity Disorder" (Philip Hazell); "Early Intervention of Indigenous Social and Emotional Health Problems" (Ernest Hunter); "Early Intervention: Its Place in the Prevention of Youth Suicide" (Penny Mitchell); "What Is Normal and What Is Abnormal?" (Robert Kosky); and "Promoting Family and Community Resilience in Indigenous Communities: Cultural Adaptation of the Resourceful Adolescent Parent Program" (Paul Harnett, Colleen Clarke, Ian Shochet). (Contains 21 references.) (JDM)

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AusEinetter
1998

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ISSN 1329-8720
Issue 3 - 1/98

AusEinetter

Early Intervention in Youth Suicide in Australia

The Commonwealth Youth Suicide Prevention Advisory Group held its last meeting in Canberra last month; up to that point it had advised Mental Health Branch, and through them the Federal Minister for Health and Family Services, on the National Youth Suicide Prevention Strategy (NYSPS). In fact YSPAG had responsibility over two and a bit years for the $13m of the Youth Suicide Prevention Initiative (most of which reaches completion by the end of 1998), but had less to do with the more recent $18m or the targeting of the programs which are just now beginning to get off the ground. Responsibility for the total package will now reside with a new Ministerial Advisory Committee which will have more formal representation from each state and territory and, it is hoped, will be able to ensure better coordination of funding and projects for Suicide Prevention between the Commonwealth and the States. YSPAG, as a committed and representative group, was ever mindful in its deliberations of the possible legacy from the Strategy and repeatedly focused on the possible long term outcomes for young people from investing such a large amount of money; how could we be sure that it was spent wisely?

The Evaluation Working Group (previously a subcommittee of YSPAG) will continue to liaise with the 34 individual programs (for brief descriptions please see http://AusEinet.flinders.edu.au), assisting the external evaluators for each program with their evaluations, and will report to the MAC about both the outputs from the Strategy and the outcomes gained. In addition, the Australian Institute for Family Studies is evaluating the whole NYSPS - as a strategy and in terms of overall outcome (for preliminary information please see http://aifs.org.au). These two processes should, between them, provide most of the answers to two major questions: "Did we in Australia get it right?" and "Where do we go from here?" In the early days YSPAG was criticised for what appeared to be somewhat of a random process of funding projects. Nothing could be further from the truth. Admittedly in the first few months there was pressure to fund some major initiatives in training for general practitioners, and, as a consequence, some felt that the funding had occurred before an overall funding model was clear. However, the rationale for each of the major areas of funding was clear (Mental Health Branch, 1995a & 1995b), each of the processes followed due tender process, and the many applications for each major area were carefully scrutinised in depth by subcommittees of YSPAG which co-opted professionals with special expertise where necessary. The overarching model adopted was that of Mrazek and Haggerty (1994), and a basic tenet within this was to attempt at least some innovative programs - not just replicate previous work from overseas. The focus of course has been on prevention - more primary and secondary perhaps than tertiary. Within this have been funded some Universal preventative programs which include mental health promotion and education to both young people, their carers, and the professionals who deal with them.

There are many programs targeted at Indicated prevention - that is at populations thought to be at increased risk (indigenous young people, rural youth, or gay and lesbian young people are good examples). Further programs have addressed Selective (or Targeted) prevention with young people who may be showing signs of early illness (homeless and marginalised youth, and/or those with previous suicidal behaviours, provide a good example). A number of programs have been funded for young people with early or first episode illness (for instance those identified as cases of depression).

Finally a smaller number of programs have been funded to examine innovative approaches in case management or rehabilitation in thecommunity. If you read Maris et al. (1992), it becomes clear that there is a process which leads up to the final behaviour of suicide; it doesn't just come out of the blue. We could call this a pathway or a 'trajectory'. It is complex and different for each individual, but background, cultural, community, family or personal historical factors prepare the ground, a series of negative events over the course of time

Funded under the National Mental Health Strategy by the Commonwealth Department of Health and Family Services

may escalate the person along the trajectory, gathering pace in the context of an illness or (for example) a personal loss, reducing the options for healthy change. At some point there is a spark which ignites the process to a speed and final direction where no intervention is likely to change the trajectory. Where we intervene as individual professionals in part depends on at what point we come across the trajectory; we do the best we can at that time. For the community, taking an overall view of the issue, it is different; there are some points along the trajectory which are more likely (that is the evidence would suggest this is the best place) to change its direction. To a certain extent the earlier we can intervene, the more likely we may be to change the trajectory. In contrast, if we intervene too early, we may not have clear evidence for just who is most at risk; our targeting may be poor, and we may 'waste' effort and resources. As individuals we need to know what works best at any given point along the trajectory so that we can do our best. As a community we probably need to know more where to place the available resources; if you like, we need to know the 'best buy'. The National Youth Suicide Prevention Strategy can be expected to provide some of the Australian evidence clarifying what may be done at which point along the trajectory. As a community we can expect that it will also clarify a little about the best buy or 'best combination of buys' to achieve reduction in the outrageous level of young suicides in this country.

At AusEinet we believe that this model of trajectory may assist us to define similar issues for early intervention in a range of mental health disorders and problems. Two of our tasks are to collect the available evidence in each case to clarify the 'trajectory', and then see whether we can move toward defining 'best buy'.

Associate Professor Graham Martin, for the AusEinet Team

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THIRD NATIONAL CONFERENCE ON CHILD AND ADOLESCENT MENTAL HEALTH
23-25 July 1998
Sydney, NSW

Theme: Families Towards 2000
The Child and Adolescent Narrative –What can they tell us?

This is the working theme for the 1998 Third National Conference on Child and Adolescent Mental health being held in Sydney. The Child and Adolescent Narrative reflects the move towards collaborative partnerships, with the focus being on listening to the stories and concerns in a compassionate collaborative manner. The Conference will be offering a wide-ranging program, including the following themes:

- The family and its changing role – looking towards 2000 and beyond
- Children and Adolescent issues
- Promotion, Prevention and Early Intervention
- Collaborative partnership frameworks with other systems
- Models of service delivery- present-future/clinical models
- Culture
- Addressing the shifting paradigms
- Listening to the Consumer-Carer

The themes of the Conference will be explored through a wide variety of sessions.

For further details regarding the Conference, please contact:
The Conference Organiser, PO Box 214, Brunswick East Australia 3057, Telephone: (61) (03) 9380 1429, Fax: (61) (03) 9380 2722, Email: conorg@ozemail.com.au

Mental Health Enhancement Program Springvale Community Health Centre - Melbourne

The mental health enhancement program at Springvale Community Health Centre was initiated in earnest two years ago to promote the mental health of children and young people as a way of preventing suicide and self harm.

More specifically, mental health enhancement is a key component of services under the Child & Youth Health Program areas at the Centre. The Springvale-Dandenong area is well known for its vibrant population of diverse cultures. A significant proportion of this population is of Asian background and/or recent migrants/refugees from former Yugoslavia, and other areas of civil conflict.

Initiatives to promote mental health and wellbeing are undertaken by the Centre collaboratively with community and other local agencies in the primary settings of school, family and community.

Child Health and Support Services at the Centre comprise a cluster of services designed to assist in the health

and well-being of pre-school and primary school aged children. Services to children are inclusive of medical, allied health and dental services. Speech therapy is also available. Psychological assessment services are provided for developmental delay, learning difficulties, and difficulties in social, emotional and behavioural adjustment. Therapy services for children (and their families) are also available. Referrals received by psychologists predominantly cover poor self-esteem, phobias, adjustment issues and/or trauma surrounding migration, parent separation, illness, death, abuse and family violence. Parent support, parent training, family therapy, and parent counselling are available at a professional level.

Youth specific services incorporate individual and family counselling, a reproductive and sexual health service, emotional and practical support for homeless youth, provision for health information, needle exchange and recreation, drug and alcohol treatment program, and group programs addressing anger management, peer education and personal development.

The Centre's holistic perspective and service delivery in respect of children and young people are clearly in accord with the findings indicated in Youth Suicide in Australia: a background monograph (Commonwealth Department of Human Services, 1995). The monograph urges 'mental health promotion and treatment within a broadly based model of holistic health care.' It also states that 'preventative work needs to target the totality of the individual's problems through a focus on both the immediate stressors and longer term vulnerabilities.'

Piloting the **Griffith Early Intervention Project** is one of several recent initiatives of the Centre in the area of mental health enhancement. Using a universal format, the FRIENDS program was trialled at a local primary school on a class of Grade 5 students, predominantly of non-English speaking background. Sessions were held weekly for 10 weeks. Booster sessions are to be conducted in the next two months.

The pilot has resulted in the Centre evaluating the FRIENDS program at two levels, namely, its appropriateness and sensitivity for children of diverse cultural backgrounds, and the practical/pragmatic issues arising from undertaking the project in a school/classroom setting. This exercise is currently receiving attention.

In view of the enthusiasm of the principal, staff and students with the program, the Centre may consider further trial sessions in 1998 - subject to availability of funds to continue this valuable work.

For further information contact Bala Mudaly, Sharon Turner, Springvale Community Health Centre, Telephone 03 9548 3255, Facsimile 03 95463465.

The Yellow Ribbon Program Worldwide and Now in Australia

Introduction

For those of you who have read "A Third Serving of Chicken Soup for the Soul", page 155 relates the story of the Emme family who lost their son Michael through suicide. Nobody realised the depth of pain he was feeling. As Michael's friends and class mates came to share the Emme's grief, a simple message evolved: "Don't ever do this; talk to someone; get help!"

From that simple message, the Light for Life Foundation was formed and the Yellow Ribbon Program was implemented. Dale & Dar Emme, his parents, are the ambassadors of the program in their home state of Colorado, the United States and internationally. They focus on raising the awareness of youth suicide, which is at an epidemic level. They believe that it not only "takes a village to raise a child"... it also takes a village to save a child. The Light for Life Foundation is an all-out effort to further education, actions and advocacy toward the prevention of youth suicide. The program's basic premise is that youth do not want to kill themselves, they just want to stop the pain. But they do need to reach out for help.

The simplicity of the program, coupled with the team work of counsellors, staff, teachers, social workers, clergy and medical practitioners in the community and schools contribute to the program's incredible effectiveness world wide.

An Australian Chapter has been formed to spread the Yellow Ribbon word nation wide and, by co-opting the help of professionals, youth themselves and all segments of the community, ensure that this invaluable adjunct to all of the current and future programs helps reduce the incidence of youth suicide.

Worldwide, since its inception in 1994, nearly a million Yellow Ribbon cards have been distributed and many hundreds of lives have been saved. In the United States the program has been adopted by many schools and colleges, endorsed by many organisations such as American Osteopathic Association, University of Colorado, Lake Geneva Wisconsin Schools and the Colorado Department of Education.

Your help in spreading the Yellow Ribbon message will go a long way to supporting the Foundation in its goals to curb the incidence of youth suicide.

For further enquiries contact the Light for Life Foundation at PO Box 6043, Halifax Street, Adelaide, 5000 or facsimile 08 8364 5730.

Parent Aide Unit

Description of Services

The Parent Aide Unit provides two related home visiting programs utilising about 35 trained volunteers (Parent Aides) and two experienced Social Workers. Both programs service Brisbane south-side suburbs and both have a child protection/injury prevention focus. In both programs Parent Aides endeavour to be available personally or by telephone at times of crisis or distress.

- **Child Protection Program** - Since 1979 this program has supported families where child abuse has been identified. Here, Parent Aides generally visit as part of a case plan developed by a Suspected Child Abuse and Neglect (SCAN) Team. It is a long term intervention (2-

3 years). Counselling is available to parents in the program who are adult victims of child abuse.

- **Bringing up Babies Safely (BUBS) Program** - Since 1995 this program has introduced Parent Aides to selected parents antenatally or following childbirth. BUBS is a short term intervention and family support program particularly during the first 12 months of a baby's life.

Outreach Services

Both programs provide home based services to families and as such are outreach services of the Social Work Department.

For further information - Richard Webb, Jo Taylor, Denise Wood, telephone 07 3840 8128, facsimile 07 3840 1665.

Westmead Hospital Psychiatry Adult Treatment Programs

The twelve-bed Adult Inpatient Treatment Unit (Ward C4a) in Westmead Hospital is oriented towards making a contribution to Early Intervention services in Western Sydney. The Unit does not have a specific catchment area although it gives preference to clients from the Western Sydney Area. It is more casemix-oriented, classifying its activity into a number of treatment programs targeted at specific diagnostic groups. Two particular target groups have an early intervention focus. The first is the Eating Disorders program which accepts a high proportion of first-onset eating disorders. The other is the First Onset of Psychosis program. This accepts referrals generally from the Western Sydney Area Early Intervention Service which operates in the community in collaboration with established community mental health services.

Further information can be obtained from Peter Tucker, Director, Adult Treatment Programs, Division of Psychological Medicine, Westmead Hospital.

Australian National Early Psychosis Project (NEPP)

NEPP was a collaborative project between the Commonwealth, State and Territory Governments of Australia to develop and promote a national model of best practice in early intervention in psychosis (Pennell et al., 1997). The project was funded by the Commonwealth Department of Health and Family Services via the National Mental Health Strategy. Extra support in the form of additional resources and funding was provided to the Project by the eight participating state and territory governments to progress the activities of the project in their region. The project managed by the Early Psychosis Prevention and Intervention Centre in Melbourne Victoria.

NEPP had three key foci: (a) service and policy development including the provision of tertiary consultation, ongoing support, advice, information, and access to expertise to aid mental health service providers and policy makers to incorporate a best practice approach; (b) professional education and training which involves provision and distribution of a range of professional development resources and activities facilitated by project coordinators; and (c) provision of information and promotion of best practice policies via a newsletter, the project resource centre, and development of clinical practice guidelines.

Many mental health clinicians across Australia will have been involved in the project in some way or another over the last two years whether through participation in training, a working party, receiving the newsletter or simply logging onto the website. The momentum and energy put into the project by these clinicians and the individual State and Territory Project Coordinators has been fantastic and has shown us that early intervention in psychosis is a realistic and achievable goal. To enhance and build upon the work that has already been undertaken through the NEPP a set of Australian Clinical Practice Guidelines for Early Psychosis have been developed; copies will shortly be available from the Early Psychosis Prevention and Intervention Centre as will copies of a video "Sally's Story" that uses a 'hypothetical' approach with an expert panel to identify and address issues of early identification during a young woman's pathway to care. It is hoped these resources will be an ongoing aid to clinicians. Unfortunately the National Early Psychosis Project has come to an end but many of the states and territories involved have agreed to continue, and have retained a Coordinator (your local Mental Health Branch can advise you as to whom the contact is) to facilitate this. Additionally the NEPP Resource Centre located on the www will continue to provide a forum for information sharing, discussion with colleagues and a centre to access information about key resource materials. The Resource Centre is located at http//:ariel.unimelb.edu.au/~nepp. 'Early Psychosis News', the newsletter utilised by the project during its life time, will continue to be produced by the EPPIC Statewide Services who are happy to provide it to agencies and organisations who express interest in receiving it.

For further information about any aspect of the National Early Psychosis Project please contact Kerryn Pennell, Deputy Director, Education, Research and Development Services of the Centre for Young People's Mental Health (incorporating EPPIC, OAS, and the EPRC) on 03 9342 2800.

A New Mental Health Information Service For Rural and Remote Australia: M H I R R A

The Gilmore Centre (previously known as the Australian Rural Health Research Institute, based at Charles Sturt University in Wagga Wagga) received funding for a proposal aimed at improving access to mental health information for people in rural and remote areas of Australia. This proposal was funded through the first National Mental Health Strategy, with a sum of $108,000 allocated for a period of two years.

From June 1996 to March 1997 the main focus was the identification of information needs of rural consumers and of

a vehicle for disseminating this information. A National Summit for Health Information Clearinghouse Providers and Database Administrators was organised in April 1997. The aim of this was to ensure that the plethora of similar work already being undertaken around the country not be duplicated due to lack of consultation. All too often funding has been allocated for a database, the database completed and then put onto a shelf with no means of accessing its contents.

It was concluded that the best means for rural/remote people to access this kind of information would be via the telephone. The Charles Sturt University team signed a Memorandum of Agreement in May 1997 with the NSW Association for Mental Health, the agreement being that NSWAMH would collaborate with CSU to develop and deliver a rural and remote mental health information service by 31 May 1998. NSWAMH then employed two part-time workers as core personnel on the project: a Database Administrator and an Information Officer. A Steering Committee was formed, appropriate software was identified, and the process of setting up the database of mental health services and associated organisations across the country began.

As a means of supporting the Information Officer with planning and delivering the service, a Reference Group was formed consisting of a number of specialists including indigenous and ethnic mental health, rural/remote emergency and education services, nursing, policy/politics, legislation and the mental health consumer consultancy.

Following its official launch at the 1998 Rural Mental Health Conference at Ballina, NSW on 27th February by the local Member for the Federal seat of Richmond, Mr Larry Anthony, the MHIRRA information service commenced operation on 2nd March.

Initial hours of operation are weekday afternoons only (from 1.30pm to 4.30pm Australian Eastern Standard Time, adjust for daylight saving) so that the Information Officer can utilise the mornings to attend to promotion of the service, chasing refunding options, and maintaining the currency of the database. Once refunding has been established, these hours may then be extended to service the different time zones more adequately.

The MHIRRA team are hoping to secure refunding through the second National Mental Health Strategy. If you are interested in assisting in the project or supporting refunding endeavours then please, do not hesitate to contact the *MHIRRA team on 02 9879 5341.*

New ADD and ADHD Support Line

Parents Carol and Steve of Coffs Harbour are setting up a much needed service to support parents and children with ADD (Attention Deficit Disorder) or ADHD (Attention Deficit Hyperactivity Disorder). Carol and Steve have had 23 years of hands-on experience with ADD and co-existing disorders, and have found through their own experiences that children with disabilities do not just have problems during office hours. They are offering a 24 hour support phone line service for parents and children with this disability, and also with the co-existing disorders that are associated with the disability.

The service will provide a sympathetic and experienced ear for parents who are frustrated, can't cope, have simply just run out of ideas, and who just need support. A great number of parents have felt isolated because of the lack of support from friends, family members and the community in general, and Carol and Steve firmly believe that support is the main ingredient when managing children with disabilities.

The service for children is aimed at teenagers, but will help children of any age. The purpose is to explain the difficulties in not understanding their disabilities, and provide the opportunity for them to talk to someone other than their parents allowing them to take out their anger by phone, rather than destroying things or hurting the people who love them.

Carol and Steve would be most appreciative of any local businesses or individuals who wish to assist with sponsoring the service. Donations may be sent to:

ADD and ADHD 24 hr Children & Parent Support Line
PO Box 6624
COFFS HARBOUR PLAZA NSW 2450

They would also welcome fundraising ideas, and offers to volunteer in manning the phone line.

Anyone requiring further information can contact Carol or Steve on 02 66541 8651 or write to the above address.

Forum on Youth and Mental Health (NESB Youth Mental Health Network)

The first of a series of forums on Youth and Mental Health organised by the NESB Youth Mental Health Network was recently held in Sydney. Entitled *Youth in Trouble: Young People, Culture, Mental Health Issues and Juvenile Justice*, the Forum was addressed by Thanh Nguyen (NSE Dept of Juvenile Justice), Vincent Doan (Open Family, Australia) and Debbie Wong (Youth Action Policy Association).

Thanh noted that young people entering the NSW Department of Juvenile Justice come from over 60 linguistic and cultural backgrounds. He offered a profile of young people who come into contact with the Department of Juvenile Justice. Factors include:

- breakdown of significant family relationships
- history of neglect, physical, emotional and sexual abuse
- learning difficulties
- limited employment opportunities
- poor coping skills
- difficulty managing emotions and behaviour
- low self esteem
- emotional instability
- a distrust of adults and authority figures
- association with negative peers groups
- alcohol and drug abuse
- alienation and feelings of powerlessness

Up to 95% of the department's clients are male. Of the young people entering the juvenile justice system in 1996/97, young people of NESB made up 22% of all

juveniles admitted into custody. The most over represented group was young people of Aboriginal background which made up 24% of the client group. The most over represented NESB groups are young people from Pacific Islander, Indo-Chinese, Lebanese and New Zealand/Maori backgrounds.

The factors associated with over representation of some NESB communities identified in the Human Rights Commission Report Juvenile Justice and Young People of Non-English Speaking Background (1994) include:

- the proportion of a particular community under the age of 25 years
- vulnerability in employment, difficulties experienced in the schooling system, vulnerability top homelessness
- selective policing policies that may impact on the number and proportion of youth from certain communities being over represented in the system
- concern has also been expressed at the relationship between ethnicity and sentencing practices by magistrates.

However, a young person's particular background does not in itself predispose the young person to offending behaviour.

Thahn also highlighted barriers for young people of NESB who come into contact with the Department of Juvenile Justice:

- communication and language barriers
- difficulties experienced by staff in working with young people from diverse cultural backgrounds
- young people being dislocated from their families and communities

The Department of Juvenile Justice is attempting to overcome some of these barriers by providing:

- an onsite fulltime psychologist at each centre
- access to clinical psychiatrists
- access to an after hours support team
- a forensic program, sexual offender program, violent offender program
- providing cross cultural counselling training

A more detailed copy of the presentations and recommendations from the forum will be available from the Transcultural Mental Health Centre in the near future. *For more information, contact Andrew Sozomenour or Maria Cassaniti on (02) 0940 3800.*

(Adapted with permission from NSW Transcultural Mental Health Centre Newsletter, Issue 13).

AusEinet National Stocktake of Early Intervention Programs

The first AusEikit will be developed this month. This will contain the first report on the National Stocktake of Early Intervention programs as well as preliminary information on the development and maintenance of an early intervention service. Updates of the Report will be published during the life of the AusEinet project as further early intervention programs are identified.

If you would like one of the National Stocktake Questionnaires or if you require further information *please contact Cathy Davis* cathy.davis@flinders.edu.au Ph 08 8357 5788 or Fax 08 8357 5484.

AusEinet Website http://auseinet.flinders.edu.au)

Have you visited the AusEinet Website recently? We are gradually adding new material to the site and would welcome your feedback and your contributions. Over the next couple of weeks, you will note the introduction of the first of our 'Hot Topics'. As the name suggests, the 'Hot Topic' page will highlight topical issues in the field of early intervention. Our first 'Hot Topic' will highlight parenting issues while the second will outline recent insights into early intervention in ADHD. We would welcome your suggestions and contributions to the 'Hot Topic' page.

Email: auseinet@flinders.edu.au

Fax: 08 8357 5484

Phone: 08 8347 5788

Some Impressions of AusEinet Workshops in Hobart and Melbourne

AusEinet held workshops in Hobart at the University of Tasmania on February 12 and in Melbourne at the University of Melbourne on February 14. It is worthwhile remarking on the differences between the workshops.

Both workshops took place in pleasant venues, and the morning and afternoon teas and lunch were delicious. In Hobart, the workshop took place in Lazenby Bistro, a new, white-tiled, sunny hall looking out over the harbour. In Melbourne, on a beautiful day, we occupied the Chapel of St Hilda's College, a modern room looking out over the pleasant College Courtyard.

Both workshops had a similar format. In the morning, there were introductions by Robert Kosky and Anne O'Hanlon to the concept of Early Intervention (EI) and to AusEinet, followed by interactive group work by participants. This two-way process was firstly aimed at giving participants an idea of AusEinet's aims and the structure of the project and secondly at giving the Auseinet team information about possible EI projects, the needs of the participants and the region they represented. After lunch, guest speakers described local EI initiatives and then the participants, again in groups, explored hypothetical case scenarios. We were keen to get some idea of how they might approach EI in real life.

Despite these similarities, the workshops, we think, developed quite differently in several respects.

Participants - In Hobart, the participants represented a wide range of people interested in or working with mental health and illness. There were many professionals, mostly young, and a diverse sample of people working in education, welfare, juvenile justice, government and non-government organisations. There were some very active consumers and carers.

In Melbourne, there was quite a different audience. Although, again, there was a wide and representative range of people working in mental health and allied fields, there was a preponderance of health managers (some very senior) and a

sprinkling of academics, some of whom were distinguished authorities in the area of EI.

Concerns- The main concerns of the groups differed considerably. The Hobart group focused on practical aspects of EI, whereas the Melbourne group explored theoretical concepts and the ramifications of EI for mental health generally. In Hobart, the group emphasised the lack of access to specialised services, the importance of the general medical practitioner, the need to improvise, work together and communicate with each other and to set up services targeted to identified (local) needs. These issues they saw as important because of the geography of Tasmania, the absence of specialists in some places and the stress on the social fabric of the State caused by youth unemployment and migration to the mainland. Consumers, especially, pointed out that they had neither the equipment nor the means to develop communications with wider groups. They wondered whether Internet access could be provided to allow access to a range of workers, carers and consumers. They also wanted a space on the AusEinet website for young people to access, chat and seek help and support. These practical issues, and there were many others, provided the flavour of the morning's discussion in Hobart.

In Melbourne, quite different concerns surfaced. Here the issues were more conceptual - how could the several services, based on historic divisions of labour, be reshaped for EI? How can the focus of interest be shifted from the tertiary services to young people? How can the current gaps between carers and professionals be bridged? What are the limitations of the medical model? Where does crisis work fit? How are the special problems of rural communities to be approached? How is the consumer voice to be maintained? Some ideas proposed were: to shift the focus from reaction to proaction; to focus more on education around "mind matters", to support local coalitions (the Hobart model!); to get hospitals to be "health services without walls"; to have life-span projects; and to establish solid links among primary health carers.

Approaches to EI - Responses to our hypothetical case scenarios also differed. The Hobart group was very practically minded and, with one exception, used a sequential model with various potential interventions along the life trajectory of the individual case. The exception was one group who, eschewing this approach, went straight to an ecological model which involved altering the interactions between child, parent and school to more facilitating and healthy styles.

The Melbourne group took a much more theoretical approach, again concerned with the concepts behind EI. Some groups used the practical, sequential model of intervening at various points along the life span. Most groups, however, used an interactive, ecological model in which the relationship between the individual, family and society was assessed and restructured to focus on opportunity rather than risk, with the aim of reaching a more adaptive outcome. A general concern, was that current models of EI are inadequate because they are conceptually too disparate. Some attempt at synthesis of EI concepts is necessary and the group felt that the AusEinet project should work towards such a synthesis - a working model of EI - as one of its outcomes.

As a result we will publish, in a future AusEinetter and on our website, an account of the models of EI which have so far been developed here and overseas, in order that we might get feedback and start to develop an Australian model which is suitable for application by workers and consumers in this country.

The differences between the workshops in Hobart and Melbourne were, to us, striking. We wondered if they were due in part to the days the workshops were held. Hobart's was on Thursday and Melbourne's on Saturday. Possibly administrators and academics were more freely available on the weekend, and the reverse was true for consumers/ carers and non-government workers. Also it was clear that people in Melbourne, probably influenced by EPPIC, have given a lot of thought at a policy and academic level to the issue of EI. That being said, the size of Tasmania and the relative freedom from historic constraints on mental health, leaves it free to make local innovations in a way that might not be possible in bigger cities and more heavily populated states.

We'd particularly like to thank our guest speakers. In Hobart, Angela Josephs and Chris Handley spoke about the Tasmanian Children's Project, which focuses on children of parents with mental illness - a clear EI target group. Kate Shipway spoke about her conceptions for mental health approaches in the school system. (More about these in future AusEinetters.) Annabel Hanke, a member of our National Reference Group, summed up the workshop and again emphasised that people in Tasmania were producing innovative projects and thinking laterally because of particular characteristics of the state, and suggested that these approaches may be instructive for AusEinet.

In Melbourne, Bruce Tonge, also a member of our National Reference Group, reported on a major project being conducted by his group at Monash and at the University of New South Wales. This project was directed at EI in people who have intellectual disability as well as emotional or behavioural problems - a challenging and easily neglected group of young people. Bruce's talk, which included some interesting models for intervention flowing from his empirical studies, resulted in much fruitful discussion and lead naturally to an exploration of EI models with our case scenarios. (Unfortunately Kerryn Pennell, who was to speak about creating EI opportunities within organisations, was ill and we missed her interesting ideas, but we hope to catch up with these in a later AusEinetter).

The overall lesson for us at AusEinet was that there are a lot of people who have given thought to EI and have many good ideas and some really interesting practical experiments and innovations. We want to gather these up and disseminate them on the net and in our newsletters. We are deeply appreciative of the enthusiasm and ideas of the groups in Hobart and Melbourne and really excited by these workshops.

Robert Kosky, Anne O'Hanlon and Pauline Dundas.

(For an 'itemised' account / summary of the workshops please see our website.)

Funded under the National Mental Health Strategy by the Commonwealth Department of Health and Family Services

For your information - this advertisement appeared in the Weekend Australian 14-15 March, 1998.

AusEinet

Australian Early Intervention Network for Mental Health in Young People

BEST PRACTICE IN MENTAL HEALTH APPLICATIONS FOR RESEARCH FUNDING

AusEinet is a developing network aimed at promoting and supporting early intervention in mental health problems. It includes child and adolescent mental health workers, primary health providers, carers and consumer groups, as well as education, juvenile justice, family and youth services.

AusEinet has the capacity to enhance funding for existing early intervention projects and to commission new projects, in order to produce practice guidelines to be used by the AusEinet national network.

Research groups interested in applying for funds may obtain an application from Anne O'Hanlon via email: aohanlon@health.adelaide.edu.au, phone 0882046802 for fax 08 82047766. Application forms can also be down-loaded from our website http://auseinet.flinders.edu.au.
Completed applications must be in **hard copy format** and sent to:

Anne O'Hanlon, Senior Project Officer, AusEinet
University of Adelaide, Department of Psychiatry
Women's & Children's Hospital
NORTH ADELAIDE SA 5006

Closing date for applications: Thursday 9th April 1998.

AusEinet is a project of The Flinders University of South Australia and the University of Adelaide, funded by the Commonwealth Department of Health and Family Services under the National Mental Health Strategy.

Overwhelming Interest in Reorientation

In Stream II of AusEinet we are placing mental health workers in agencies that wish to reorientate their service to early intervention. The aim is to collaborate with agency staff or members of a community group, helping them adopt or develop an early intervention approach to the mental health issues that affect children or young people.
We have been overwhelmed with the response to the call for tenders. Lodgement of tenders closed on 6 March 1998 with tenders being received from a diverse range of agencies across Australia. In the next month we will have the difficult job of selecting the successful tenderers. Our Senior Project Officer, Anne O'Hanlon, will be working closely with these agencies throughout the period of the placement, from the initial selection and training of personnel to the final evaluation of the placement.
It is recognised that reorientation to early intervention not only has enormous potential to avert serious and disabling conditions from developing, but that there are also numerous obstacles and barriers which inhibit the effective application of early intervention approaches. Through the Stream II placement of mental health workers we hope to learn a great deal about what does and doesn't work in agencies and community groups, which can then be shared through the network.
By the time the next AusEinetter goes to print the mental health workers should have commenced. A brief outline of each placement will be included in the next edition.

AusEinet Database

The AusEinet database is steadily developing. To assist us please complete the following details and forward to AusEinet if you would like to be informed of future AusEinet activities, nationally or in your own State or Territory.

Name: .....

Organisation: .....

Address: .....

.....

.....P/C.....

Telephone:.....Facsimile:.....

Email: .....

Return to AusEinet C/- CAMHS, Flinders Medical Centre, Bedford Park SA 5042. Telephone: 08 8357 5788 Facsimile: 08 8357 5484 Email: auseinet@flinders.edu.au

THE NEXT ISSUE WILL BE PRODUCED IN JUNE.

DEADLINE FOR MATERIAL WILL BE **FRIDAY 5TH JUNE 1998**

PLEASE LET US KNOW WHAT YOU ARE DOING. CONTACT AUSEINET WITH SUGGESTIONS FOR TOPICS TO BE COVERED.

AUSEINET WEBSITE ADDRESS
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Funded under the National Mental Health Strategy by the Commonwealth Department of Health and Family Services

ISSN 1329-8720
Issue 4 - 2/98

AusEinetter

Guest Editorial

Professor Patrick McGorry

Future Pathways for Prevention and Early Intervention: "Prevention for the Nasty Nineties"

One of the consequences of the creation of a truly national momentum in mental health through the very successful National Mental Health Strategy has been that prevention and early intervention programs have at last become part of the landscape of Australian psychiatry in a myriad of ways. This is a remarkable transformation in this era of economic rationalism, though it shouldn't be, since such programs have the potential to deliver significant gains in cost-effectiveness if properly planned and developed. Federal funding of national networks and programs notably AusEinet, the National Early Psychosis Project and the Griffith Early Intervention Project has been catalytic of an organic process of reform. How can this overdue growth, tenuously based upon time-limited funding support, be consolidated into a lasting and more systematic preventive reform? I have the following ideas.

Firstly, the second National Mental Health Strategy is now under way. Let us examine some of its initial directions. It is wisely focusing on prevention, partnerships and cost-effectiveness as its key themes. If we link these themes, especially the first and last, to the (now legendary!) framework of Mrazek and Haggerty (1994), we are likely to achieve more as mental health professionals by concentrating upon indicated prevention and early case identification. Even these remain major challenges for most of our systems of care at present. Wider population-based approaches, while potentially much more powerful, should be primarily of research interest at present (yet should receive urgent support from this quarter), since the intervention variables are largely beyond our direct influence as mental health professionals, are poorly understood, and are mercurial in their response to other societal influences. I would like to see the bulk of prevention funding in the second National Mental Health Strategy targeted to what I have called "realistic" preventive interventions (indicated prevention and early case identification) However, I repeat, substantial research funding should be devoted to understanding better the primary risk factors and determinants of mental disorders and in what ways we should intervene for maximum effect. I realise this suggestion may be controversial, yet fear we could waste a lot of money through broad intervention programs which have shaky foundations and which could easily be overwhelmed by influences outside our control. Of course once such broader strategies have a sounder basis they may well be the preferred approach.

The focus of the National Strategy will be broadened beyond the persistent psychoses and this is overdue and welcome. However, this extension of focus and inclusivity should not be at the expense of gains already made. There is a a long way to go even in the psychoses. Early intervention is still by no means the rule and the quality of care around the country still leaves a lot to be desired. It would be disastrous if the arguments to shift resources away from the psychotic disorders to other neglected areas were to succeed. These arguments are loosely derived from the influential report on the "Global Burden of Disease" by Murray and Lopez (1996), which highlights the high levels of disability conferred on the global population by high prevalence mental disorders, notably, but not only, depression. The logical conclusion from this report should be that spending on research and clinical interventions in mental disorders should be significantly increased across the board as a proportion of total health spending. The narrower and short sighted view is that an internal shift of funding within mental health is all that is required. This is a major mistake which would lead to a recurrence of the internal struggles and schisms that have bedevilled mental health in its efforts to achieve equity in health and research spending. In increasing inclusivity within the second National Mental Health Strategy, we must also ensure that the focus is inclusive of a range of disorders - not merely depression, but notably eating disorders

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severe personality disorders and a range of anxiety disorders, especially PTSD and OCD. These serious and potentially serious mental disorders of high and low prevalence all need to be included, particularly now that thanks to the work of Dr. Harvey Whiteford and the support of Dr. Wooldridge and his Department, the Strategy will have substantial impact. We also need differing strategies for early intervention for high and low prevalence disorders, with the former being especially dependent on a skilled and well supported primary care system.

Secondly, if we accept the notion that the onset phase of disorders is where the action is from a realistic prevention standpoint, the inevitable corollary of this, at least for the major mental disorders of adult life, is that adolescent and adult mental health services need to blend their systems much more closely, break down mystical cultural barriers and overcome damaging discontinuities of care. That is, we need to work together and restructure, and learn to better meet the needs of young people with emerging mental disorders. If we examine the median age of onset of virtually all adult mental disorders, we see that it lies in the 15-25 age range or thereabouts. We also see very high prevalence rates of disorder in both the older adolescent age range, and particularly the young adult age range (27% in the recent National Mental Health Survey). Within CAMHS services, we are just beginning to facilitate better access to specialist care, but we still lack the resources to provide such care to very many of those who need it, and we also lack the knowledge to distinguish between those who could be treated in a well-trained and supported primary care network. When it comes to the grossly neglected young adult population, we cannot provide even rudimentary access to care for the vast majority. Yet this is where most of the rapid increase in morbidity and mortality from mental disorders has occurred in the developed world in recent decades. It is the group which has contributed most to the increase in youth suicide, yet even in Victoria where there has been a specific taskforce created on the back of this wave of community concern, this group has so far failed to benefit from the new funding which is flowing from the report. This is an enomous gap in research and preventively oriented clinical care which people need to get their heads and wallets around urgently. There is a "developmental burden of disease" and it is falling disproportionately, for a variety of poorly understood reasons, on older adolescents and young adults (Rutter and Smith 1995). The global burden of disease report also points out that the impact of disability at this phase of life is at its peak on economic and value-based grounds. Finally, the process of transition from childhood to adulthood has been undergoing a significant change. Adolescence is starting earlier and finishing later, and its component strands are much less synchronous than twenty or thirty years ago. Developmentally, adolescence no longer terminates as one walks out the school gate for the last time (if it ever did!), as our service structures in psychiatry would suggest. Other government services have recognised the emergence of youth culture and the special needs of young people much more rapidly than mental health services. Paediatrics and adolescent medicine have not had to confront this so starkly, since adolescence in recent decades has become a period of relatively good and improving physical health. However it has become a period of poor and worsening mental health which extends into young adulthood and almost certainly deteriorates further during this phase. This is made more likely by the reduced access to specialist mental health services especially in disadvantaged areas, and the worsening social environment for young adults. I believe this is one of the major challenges for psychiatry over the next decade and it aligns very closely with a preventive mental health agenda.

Finally, I have a proposal, which, if I have not upset too many preventively-oriented readers by now, I hope will stimulate some discussion and support. I think we need some continuing and robust structures to carry prevention and early intervention forward beyond the life of AusEinet et al. and the National Strategy and to nurture the talent and creativity which has emerged. An important example would be a substantial national network to continue work in every state and territory in preventive psychiatry. I believe a preventive psychiatry centre should be established in each state to initiate and coordinate a network of preventive intervention programs and projects. This could be jointly funded by Federal and State governments. A useful model is the National Network of centres for refugee survivors of torture and trauma. However an early intervention/prevention network could be more uniform and have a different pattern of work. This model would embed some of the substantial benefits of the preventive networks of the national strategies into the fabric of the mental health system across the country and enhance further progress. Something similar has already been recommended on several occasions, for example in the National Goals and Targets for Mental Health and in the Mrazek and Haggerty monograph in the USA. The detailed logic and blueprint has been partially developed but could be worked up further. At the conclusion of the National Early Psychosis Project, I wrote to all State Directors of Mental Health highlighting the need to continue the preventive momentum beyond NEPP and Aussienet. The response was generally favorable and I think there are major pluses for the Commonwealth and the States, as well as consumers, in a proposal of the kind I have outlined. What do you think?

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Guest Editorial

Professor Bruce Tonge

Intellectual Disability and Mental Health: a neglected issue of major importance.

The nature and prevalence of mental health problems in people with intellectual disability (ID) are poorly understood. The burden, stress and cost these place on the individual and the family and other carers are generally not acknowledged. Little is known about factors that contribute to these mental health problems and what interventions might prevent or relieve this suffering although it is erroneously assumed that what works for the general population will also help those with ID.

In an attempt to begin to address this problem my colleague Stewart Einfeld (University of NSW) and I, with the essential assistance of grants from the Public Health Research and Development Committee of the NH&MRC, have been conducting a follow-up study of emotional and behavioural problems in an epidemiological sample of young people with ID aged 4-18 years living in NSW and Victoria. The study participants are total of 454 young people from a total population of around 172,900 as well as children with specific syndromes namely Fragile X (64), Prader Willi (58), Williams (63), Down (70) and Autism (367). This study will shed light on risk and predictor factors for psychopathology as the group is followed beyond 2000 but already there are a number of findings of great concern.

The prevalence of clinically significant emotional and behavioural problems is around 40%. This finding concurs with other overseas studies. The prevalence of ID in the general population is 2-3%. Therefore, the problem of serious psychopathology in those with ID is *a bigger problem in the community than schizophrenia* (with a lifetime prevalence of around 1%).

Age, sex and IQ level do not significantly affect the prevalence of psychiatric disorder with the exception of those with profound levels of ID who have lower levels of psychopathology. These findings are remarkably different from those in the general childhood population.

Only 9% of those we studied who had psychiatric disorders had received specialist help and 47% of these clinically disturbed young people and their carers had received no help from any professional. This means that in NSW for example we estimate 765 young people with ID and severe mental health problems do not receive any assistance.

This work has also highlighted a number of areas for potential early intervention and mental health promotion.

1. Assessment of the cause of ID. Around 40% of our sample had not received a thorough medical assessment. Further assessment revealed a known cause in a further 20% of the group. This is not just an academic exercise. Families are often relieved to have an explanation, and when indicated, genetic counselling may help prevent the birth of further affected children. Genetic syndromes may have specific behavioural problems (behaviour phenotypes), knowledge of which is helpful to parents and carers. For example children with Williams syndrome need little sleep and children with Fragile X syndrome are naturally very shy.
2. The value of medical assessment. ID is associated with increased risk of medical problems many of which can also contribute to disturbed behaviour. For example epilepsy is common, but may be undiagnosed or inadequately reviewed and treated. Sleep apnoea from congenital nasal abnormalities may cause lethargy, unstable behaviour and impair learning. Sensory impairments may also be inadequately managed and cause further handicap.
3. Importance of psychiatric assessment. Although ID and impaired communication skills complicate the assessment of emotional and behavioural problems, it is still possible to take a history from informants, observe the child and come to some understanding of the meaning and possible causes of the behaviour. For example depressive illness, anxiety disorders
   Tourette's syndrome, ADHD, OCD, adjustment disorders and the full range of psychiatric disorders can be seen and these problems may respond to the usual treatments although modifications to behavioural interventions may be necessary and cognitive therapies may not always apply.
4. The experience of severe psychosocial stress. These young people are at a high risk for disruptions in their care and attachments, including abuse and neglect, yet have limited intellectual and emotional resources to cope. Parents also experience isolation, grief and community rejection. Not surprisingly, some young people with ID have features of post traumatic stress disorder.
5. The role of psychotropic medication. Many young people with ID are prescribed medication to try to control behaviour. Up to 80% of those in institutional care are often taking high doses of a complex cocktail of psychotropic drugs. Not infrequently their disturbed behaviour, such as restlessness, is due to drug side effects. Conversely young people with psychiatric disorders such as depression and ADHD are not receiving treatment with effective medications.
6. The need for review of cognitive ability. Many children with ID have not had adequate psychological assessment or have not had a review for many years. An understanding of intellectual strengths and deficits helps teachers plan educational programs and assists parents and carers to understand the developmental level of the child. For example features of inattention and distractability are appropriate in a ten year old boy with the developmental level of a 3 year old and do not necessarily indicate attention deficit hyperactivity disorder.

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Perhaps the biggest hurdle in providing effective early intervention services to this significantly disadvantaged and at risk group is that of "diagnostic overshadowing". This is the tendency for professionals and the community to explain all the behaviour of a person with ID as being due to their ID. As a consequence medical illness, psychiatric disorder, appropriate reactions to psychosocial disadvantage, family burden, drug side effects, and attempts to communicate are neglected or ignored because of the assumption that ID explains all. Simple early interventions such as the provision of home help, respite care, advice on behavioural management, parenting skills training, parental grief counselling and effective continuity of case management might prove to be powerful preventive measures. A necessary first step in the promotion of the mental health of those with ID is the education of primary health care workers. For example the training of GPs in assessment and case management skills.

Both the financial and emotional cost of mental health problems in persons with ID is great. For example extra burden on families, parental unemployment, residential care, workers compensation, staff sick leave, school disruption and aide time, property damage and personal injury, reduced employability and pensions, police, legal and forensic demands may all occur. We can no longer afford to ignore the suffering and extra burden that mental health problems place on those with ID and their families and carers. Therefore, this neglected issue needs to become a focus of the next Commonwealth Mental Health Services Strategy.

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Guest Editorial

Professor Philip Hazell

Early Intervention for Attention-Deficit Hyperactivity Disorder

Children in Australia with Attention-Deficit Hyperactivity Disorder (ADHD) are most likely to present for assessment and treatment at around 8-9 years of age. Retrospective accounts from parents suggest specific symptoms of ADHD will have been present for about three years[1], although many parents will describe arousal problems dating back to infancy. Early age of onset of ADHD symptoms is associated with higher rates of comorbidity with conduct disorder, and also predicts more severe symptoms and disability by 8-9 years.[2,3] However, younger age of the child at presentation predicts a more favourable short to medium term response to psychostimulant treatment,[4,5] although whether this is truly an age effect or an effect of briefer duration of symptoms is not certain. Unpublished data from our regional survey favour the latter explanation.

Treating very young children with ADHD, especially where this involves pharmacotherapy, has been viewed ambivalently by many clinicians. Published practice guidelines consider the very young a special population, and generally advise caution. Many clinics (including my own) have actively discouraged the referral of preschool children suspected of having ADHD. There is a question mark over the predictive validity of the ADHD diagnosis in preschool children, since only about one half of preschoolers identified as hyperactive will meet criteria for ADHD in middle childhood.[6,7] In addition, once a child has been prescribed psychostimulant medication, it can be a very difficult decision to reverse, owing to anxiety on the part of both parents and teachers about recurrence of the child's problems.

While we remain conservative about the early introduction of pharmacotherapy, what about other interventions? Although there is substantial literature examining strategies directed to early childhood behaviour, a search of databases available on-line yielded only one study specifically directed to early intervention with ADHD. Barkley et al.[8] randomly assigned hyperactive-aggressive kindergarten children to parent training, special classroom behaviour management, a combination of parent training and classroom management, or no treatment. All groups improved with time, but a treatment effect was identified only for the classroom management group. The treatment benefits did not generalise outside the classroom. A significant barrier to parent training was sustaining parent participation in the program.

While the data concerning benefits of early intervention for ADHD are limited, a preliminary conclusion would be that early treatment with psychostimulant medication is likely to be effective, but many children would receive treatment unnecessarily. We need to identify more reliable markers of ADHD in preschool children. In the meantime, a conservative approach is warranted, but many clinicians will be confronted by the parents of successfully treated 7 and 8 year olds who say "This is wonderful, but why didn't you do something sooner?" Screening for ADHD at school entry would be helpful to schools planning the allocation of special resources for children who are likely to have classroom behaviour and academic problems, but only if these resources are available. Such screening is unlikely to be helpful in streaming parents into special training programs. For preschool children, intervention is better directed to their overt behaviour problems. Parent training could be accessed through early childhood clinics, preschools, community

health centres or tertiary referral centres. We should not underestimate the value of books and videos on early childhood behaviour management that are readily available to parents at bookstores, video outlets, and pharmacies. We should also not discount the wisdom about parenting that can be passed from one generation to another.

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For further information contact Professor Philip Hazell, Child Psychiatry Service, Wallsend Hospital, Telephone 0249211270 Facsimile 02 4961 0731

The Benevolent Society, Centre for Children: Early Intervention Programs - New South Wales

The Benevolent Society's early intervention programs aim to give children a better start in life by supporting parents who are experiencing extra stress during pregnancy and their child's early years.

Early Intervention/Prevention services have been an important part of the Benevolent Society for more than ten years. Currently, the multidisciplinary staff which includes psychologists, social workers, clinical nurse specialists and child and family psychotherapists, work with up to 200 families each year in four programs. These programs are:

Home Start: a volunteer home visiting service, working with low risk families, in the inner west and eastern areas, predominantly funded by DOCS

Infant-Parent: shorter term interventions and parenting groups, moderate risk families, training and consultancy to other professionals, funded by fee for service and the Benevolent Society

Families Together: home visiting, moderate to high risk families where a parent has a long term mental illness, funded by the Benevolent Society, DOCS and AMP

EIP: the original early intervention program, home-based work with high risk families, funded by South Eastern Sydney Area Health

Work in these programs is based on three internationally proven practices:

- intervene as early as possible
- visit the family at home
- work long term, when necessary, to promote change

The focus of the work is on providing timely responses to factors which are impinging on the ability of families to provide nurturing environments for their children. In this way, problems are prevented from deteriorating to the extent that abuse occurs or there are negative effects on a child's present and future development. Interventions range from practical support to parent/infant psychotherapy. Common issues dealt with include:

- post natal depression
- domestic violence
- mental illness
- substance abuse
- parent's history of abuse in childhood
- social isolation
- problems in accessing community resources
- poverty
- multiple birth
- premature birth
- child or parental disability

For further information, Contact Judith Edwards, Senior Manager, Early Intervention, Benevolent Society of NSW PO Box 171, PADDINGTON. NSW 2021. Phone: 02 9365 7999; Fax: 02 9365 7937

The Benevolent Society Centre for Children
is hosting an
International Early Intervention Conference
on
Monday 14th & Tuesday 15th September 1998
at the Swiss Grand Hotel, Bondi, NSW

Enquiries please contact
Judith Edwards, Senior Manager
Benevolent Society of NSW
PO Box 171, PADDINGTON NSW 2021
Ph 02 9365 7999, Fax 02 9365 7937

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The Tasmanian Children's Project

The Tasmanian Children's Project is a collaborative venture between the School of Nursing (University of Tasmania) and the Mental Health Program (Department of Community and Health Services, Southern Region). It is a modified replication study based on the Children's Project conducted by the Early Psychosis Research Centre, University of Melbourne, during 1993-1996.

The aims of the project are to:

- Estimate the number of children in Southern Tasmania who have a parent/carer with a mental illness
- Identify the types of support that are perceived to be needed by parents, children and mental health service providers
- Identify the current level of support available, with particular emphasis on identifying service gaps
- Identify risk and protective factors for children of parents/carers with a mental illness
- Inform the relevant care agencies, policy makers and program planners of the service needs of the study population
- Recommend options for effectively supporting children and families with a parent/carer with mental illness.

Stage 1 of the project involves several components of data collection:

- Epidemiological data to illustrate the nature and scope of the issue
- Analysis of needs identified by parents with a mental illness, their children, and mental health service providers
- Risk and protective factors of children who have a parent with mental illness

The research methodology incorporates surveys, focus groups and semi-structured interviews utilising psychometric instruments. The aim is to obtain both qualitative and quantitative data. Further innovative aspects involve the broadening of mental illness beyond psychotic and major affective disorders, the inclusion of paternal and maternal mental illness and the direct sampling of children.

Stage 2 of the project aims to utilise the data and recommendations collected to facilitate the development of models of service delivery oriented towards the needs of all members of affected families, within a collaborative multi-system framework.

For more information contact Angela Josephs or Chris Handley, telephone (03) 6233 8612.

Derwent Support Service – Glenorchy, Tasmania

The Derwent Support Service began in February 1995 and is part of the Department of Education, Community and Cultural Development. It comprises educational psychologists, special education support teachers, social workers, speech pathologists and curriculum officers.

The key function of the service is to provide a range of supports to enhance the educational opportunities of students who are disadvantaged as a result of disability, gender, ethnicity, aboriginality, poverty, isolation and other circumstances which exacerbate educational disadvantage, such as pregnancy, homelessness, abuse and ill-health.

Key issues are:

- problems relating to diagnosis and therapeutic treatment, especially when other disadvantaging factors co-exist;
- unclear process for collaboration between mental health services and educational services;
- limited range of mental health services in the public sector, particularly for isolated and poor families;
- limited understanding among school personnel of the implications of mental health problems in young people;
- historically a segregated approach to educating young people with mental health problems (this now conflicts with the inclusive school system in Tasmania);
- how to maintain students in school wherever possible, on a part-time or full-time basis, whilst taking into account the therapeutic needs of each student.

There are several opportunities for promoting early intervention in the Derwent District:

- describing therapeutic and educational services available in the district for young people with mental health problems, as well as the procedures for accessing those services;
- identifying gaps in service provision;
- exploring links and networks between agencies;
- investigating 'best practice' models of school-based and service-based early detection and intervention currently being implemented in other states/systems/countries.

For more information contact Kate Shipway, Manager, Derwent Support Services, Timsbury Road, Glenorchy, Tasmania, 7010, telephone 03 6273 5137.

Baptist Community Care, Victoria

Baptist Community Care is an agency of the Baptist Union of Victoria which provides care to the community in many areas including: youth services, disability services and family counselling. Early intervention strategies are incorporated into all of its programs as part of its model of service provision. As such, it is applied to prevent crisis occurring or if crisis occurs, in minimising the crisis to prevent harm to the client. Several programs are operated by Baptist Community Care, each of which has its own emphasis. All program areas place a strong emphasis on promoting mental health and adopt holistic and case management approach in support of clients.

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Cryout: Youth Outreach Counselling Services: This is a youth out-reach counselling service focusing on sexual assault and youth suicide among other issues. The model combines a youth worker and clinical psychology approach. Youths who express a need for counselling or who are referred, are given assistance to deal with their concerns before they cause destruction in the young person's life or relationships. Problems dealt with include low self esteem, suicide ideation, anxiety and depression. CRYOUT facilitates COOL (Control of One's Own Life), C.A.L.M. (Control Anger Learning Model), CHAMP (Child Abuse Management Program) and self-esteem group programs aimed to assist young people experiencing difficulties and improve communication skills, manage anger and develop self esteem.

RISE: Educational Support Program: this program assists high risk adolescents with their educational needs in order to prevent exclusion or under achievement at school and to prevent the disruption to home life that often accompanies problems at school. The program provides intensive individual support, advocacy and tutoring. The program' focus is on young people who are homeless or at risk of homelessness. The RISE Program also facilitates group programs that provides pre-vocational and life skills for 'high' at risk adolescents who are early school leavers.

PATAS (Parent Education and Support Program): The Parents Adolescent Training and support program aimed to enhance the skills and knowledge of parents in providing a supportive family environment for at-risk adolescents. Support is offered on an individual bases or through group programs. A series of three week courses were held throughout the year with a focus on communication skills, stress management for parents, positive parenting skills and sibling rivalry. The courses were actively supported and both positive and practical benefits wee provided to participants. The Parent Educator also attended various community group meetings in the Region to contribute support, assistance and guidance to parents.

Teen Parenting and Support Program: The Teen parenting program offers teenage parents individual support and peer support networks to assist with parenting life skills, income support and adopts a holistic approach to assisting young people with infants.

For further information contact Mal Collings, Baptist Community Care, Gippsland, Telephone 03 5176 1322, Facsimile 03 5174 5982

Bethany House, NSW

Bethany House is an innovative and exciting approach that provides a safety net for children in the age groups between 10 years and 14 years of age who are 'at risk'. Bethany House provides an alternate education setting designed to meet the needs of students who are at risk of becoming marginalised. The approach utilised individualises education programs specific to each child's needs, providing support for school communities, class teachers and importantly, supporting parents and care-givers by assisting them to develop parenting skills. Children from Catholic, Independant and State Schools are eligible for both the crisis and outreach programs.

The aims of Bethany House are to:

- provide an alternative education environment, focusing on early intervention for students at risk in mainstream schools and for whom the schools do not have the resources to cater
- use a holistic approach to education with opportunities for each student to experience success

It caters for students who are in years five to eight and experience one or more of the following:

- are school refusers or chronic truants
- have been expelled or are in danger of being expelled from mainstream schooling
- are not experiencing success in the mainstream
- are at risk of suicide
- exhibit constant destructive behaviour
- are isolates, displaying withdrawn behaviour
- are emotionally disturbed
- have a dysfunctional family life
- are homeless or at risk of becoming homeless
- are abused children
- are abusive or 'acting out'

The team is multi-disciplinary, involving teachers, a family support person and youth workers. The "In-house Crisis" program caters for 8 students in crisis and is a day program that emphasises numeracy, literacy, self esteem building, conflict resolution and decision making. Children involved in this program attend Bethany House for 4 days and their Home School each Wednesday. This day ensures that they do not lose contact with friends or their identity with their school. The "Outreach", Family Support Service enables Team Members to visit schools and families. This provides a positive link between home and school, assists teachers to maximise educational opportunities for identified students and enhances the work of teachers by providing assistance on an individual basis. Additionally, the "Outreach" program has the capacity to enhance communication between the community and the school and to enable wide networking with community agencies and services. Referrals are accepted from anyone within the Hunter Valley.

Support for school communities is offered through an exciting range of workshops that focus on pastoral issues and staff formation. A selection of parent workshops are also available. Some of the day programs offered are Pastoral Care and Your School, Visioning, Abuse, Engaging a Reluctant Student, An Introduction to Quality Schools and Choice Theory, Implementing a School Based Sexuality Program, Grief and Grieving, Youth Suicide, Homeless Youth. Visit our website http://users.hunterlink.net.au/

~dedjk/ for further information about the course content, methods of delivery and booking.
For further information, please contact: Alison Lidbury, Community Liaison Officer. PO Box 34, Maitland 2320. Phone: 0249 344 158; Fax: 0249 344 168. Email: bethany.house@hunterlink.net.

Innovative Directions for Youth in Mental Health, Queensland

Young People with Unlimited Opportunities and Real Life Experiences United (Y.U.R.U.) is an innovative program designed to provide early intervention, prevention, and promotion of personal recovery. Y.U.R.U. is a highly specialised program that meets the unique needs of young people, aged 14 to 27, who are living with a challenging mental health disorder, including early psychosis. It is history making that this program is the first joint initiative aimed at bridging the gap between Child and Youth and Adult Mental Health Rehabilitation Services, in Queensland. This program is supported by policy initiatives from the "Future Directions for Child and Youth Mental Health Services: Queensland Mental Health Policy Statement 1996", which emphasises continuity of care, relapse prevention and psychosocial rehabilitation and the importance of early intervention.

The Y.U.R.U. program aims to promote better outcomes for young people with challenging mental health issues, i.e. minimising risk factors, improve level of functioning and targeting the problems and difficulties young people face in a social and developmental context. The initial phase of Y.U.R.U. runs for ten consecutive weeks. The program addresses issues such as symptom management, friendship and family dynamics, communication, anger and stress management, risk and protective factors, self esteem, leisure and recreation, coping strategies and adaptive skills for overcoming developmental difficulties. The follow up phase occurs one month after the successful completion of the initial phase which has an adventure based orientation. Y.U.R.U. has been formally and comprehensively evaluated. As a result of this evaluation, Y.U.R.U. is being implemented on an ongoing basis with a commitment to provide young people living with a challenging mental health disorder with purpose, direction and opportunities to grow and change in their own personal recovery.
For further information contact Pam Samra Integrated Mental Health Services or Lara Denman Child & Youth Mental Health Services, Southport, Gold Coast Q 4215, telephone 07 5571 8950, 07 5537 0622 or facsimile 07 5571 8909 or 07 5537 0614

Adolescent Sex Offender Treatment Program: Children's Protection Society, Victoria

In 1993, the Children's Protection Society established the Child Sexual Abuse Treatment Program for victims of sexual abuse and their non offending caregivers. This program provides therapeutic counselling services for children up to 17 years residing in the Northern region of Melbourne. In November 1994, the Adolescent Sex Offender Treatment program was established. This program provides therapeutic counselling to young people aged 10-17 who have committed a sexual offence that has been reported to the police. Initially, this program provided services to young people throughout Victoria, but due to excessive demand on the service and the difficulty with distance and for rural participants, it now offers services to those living within Metropolitan Melbourne,

The Adolescent Sex Offender Treatment Program provides:
- assessment to determine risk of reoffence and treatment requirements
- groupwork counselling programs
- individual counselling
- family counselling
- family reunification counselling

The young people attending the Adolescent Sex Offender Treatment program have presented with a range of mental health issues including:
- PTSD symptoms
- past experiences of sexual abuse
- past experience of physical abuse
- past experience of witnessing domestic violence
- poor family relationships
- anger management problems
- conflict management problems
- social isolation
- communication difficulties
- substance abuse issues
- family breakdown
- self mutilation
- suicidal ideation
- disorders such as conduct, ADD, ADHD, attachment, eating

The main objective of the Adolescent Sex Offender Treatment Program's work with these young men is to minimise the risk of reoffence. In order to successfully achieve this, the program not only addresses the presenting behaviour but addresses the issues mentioned above. The initial assessment provides an indication of the issues that the young person will need to address throughout the treatment process. Groupwork provides the main avenue in which to address issues of poor peer relationships, communication difficulties, anger management and conflict resolution with the majority

of time being spent on sexual behaviours and strategies to manage these.

Individual counselling addresses issues of the young person's own experiences of abuse and feelings of powerlessness. Family counselling provides the opportunity to address family conflict and where appropriate, family reconstruction.

All of these strategies are viewed as early intervention strategies in the prevention of further sexual abuse as well as the prevention of depression, reduction in self esteem and family breakdown. As adult perpetrators may commit in excess of 300 offences in their lifetime, work with young people is reducing the number of future victims of sexual assault and therefore the number of mental health issues these children and young people may face as a consequence of that abuse.

For further information, contact Karen Flanagan, co-ordinator, Adolescent Sex Offender Treatment Program, Children's Protection Society. 70 Altona Street West Heidelberg 3081. Phone (03) 9458 3566; Fax: (03) 9457 6057.

STARTTS Youth Program NSW

STARTTS, the Service for the Treatment and Rehabilitation of Torture and Trauma Survivors, provides a specific youth program which complements the work of STARTTS and undertakes work in conjunction with the STARTTS bi-cultural counsellor and community based organisations to meet its goals. The target group of the youth program is young people aged 10 to 18 years of age, living in NSW and coming from a refugee or refugee like situation.

Presenting issues include loss, separation, self efficacy, anger, anxiety and depression. The youth program also tries to address other 'normal' issues such as conflict with the family, specifically focusing on conflict caused by different cultures in settlement.

The STARTT's youth program develops a range of programs for young people, based on the most common presenting needs of participants. Strategies employed vary, and include self support groups for different ethnic communities, a homework help program, a camping program and the development of training and other materials. Three current programs are:

Middle Eastern Youth Video Project: this project is developing training materials for school teachers to assist them in teaching young people from middle eastern backgrounds in the classroom. This project received funding from the Australia Council for the Arts and is employing a combination of video making with action research to develop the materials.

Serbian Youth Group, "Talking Tough": is a program based on the Victorian Foundation for Survivors of Torture, "Working with refugees young people" kit. The group is being run in conjunction with the Serbian Orthodox Welfare Centre.

Winter Camping Program: In July, the youth worker will be taking a group of approximately 25 young people to the ACT to teach them about the differences between the Australian political system and the political system of their place of origin in a hope to demystify fears or misconceptions they may have about Australia and the Australian political system.

For further information, contact Gary Cachia, Youth Development Officer STARTTS , Telephone 02 9794 1907, Facsimile 02 9794 1910.

Graduate Diploma in Young People's Mental Health

The Graduate Diploma in Mental Health Sciences (Young People's Mental Health) is offered via distance education by the Department of Psychiatry, Faculty of Medicine, Dentistry and Health Sciences, at The University of Melbourne.

The course is directed towards those who wish to acquire the skills necessary to remain at the forefront of preventive psychiatry in young people's mental health.

The course will be of particular interest to health-care professionals working in both adult and adolescent mental health fields, and the course is open to graduates in psychiatry, medicine, psychology, nursing, occupational therapy, social work or other related disciplines. Applications are accepted in October for the March intake, with applications closing early in June for the mid-year intake.

The course consists of seven subjects, all offered only via distance education, to be completed part-time over a two year period. In semester 1 and 2 of the course the following subjects are taken: Theories of Adolescent Development: Preventive Community Psychiatry and Young People, and Mental Illness in Young People: The Biopsychosocial-Developmental Perspective.

In semesters 3 and 4 of the course subjects consist of Assessment & Young People, Applications of the Preventive Model 1: Biological Interventions, Applications of the Preventive Model II: Psychosocial Interventions, and Service Delivery and Optimising Contexts of Treatment.

The student intake in 1998 included mental health professionals from Victoria, New South Wales, Western Australia, South Australia, Northern Territory and Queensland. Each week during the course students received a

videotape and reading pack with notes and additional references. The Course Coordinator has been available for regular telephone support and students in more remote locations have been provided with all the necessary reading materials to complete their written assignments.

For further information and application details, contact John Gleeson, Course Coordinator on 03 9342 2932 or email on j.gleeson@medicine.unimelb.edu.au.

Realising the Potential
The Second National Conference on Early Psychosis

EPPIC Statewide Service is pleased to announce The Second National Conference on Early Psychosis-Realising the Potential to be held in Hobart, Tasmania, September 4-5 1998.

Reflecting the strong national focus on strategies for prevention in early psychosis that has resulted from major initiatives during 1996 and 1997 such as Verging on Reality and the National Early Psychosis Project, this Conference will provide an opportunity for people to consolidate their learning in this field, and showcase the strong and diverse range of clinical interventions and research activities which have been undertaken on a national level.

Given the recent emphasis on early intervention in psychosis nationally, this Conference will offer mental health professionals who have contributed to major reforms a chance to embed theory into practice; provide an opportunity for many early psychosis groups to present their programs to a national audience; and challenge mental health professionals in this field to think to the future and ways of realising the potential of current strategies in a meaningful way for long-term impact.

The timing of the Conference compliments the Eighth Mental Health Services Conference (TheMHS) Conference to be held 7-9 September 1998 in Hobart.

To receive a "Call for Papers" brochure for The Second National Conference on Early Psychosis-Realising the Potential, fax your contact details marked Attention Coordinator, EPPIC Statewide Services - request for call for papers to 03 9342 2941.

EPPIC, Locked Bag 10, PARKVILLE, VIC 3052
http://www.vicnet.net.au/~eppic Telephone +61 3 9342 2800
Facsimile +61 3 9342 2941.

Reorientation moving ahead

Eight mental health workers are about to start work in a range of agencies across Australia, which have been successful in tendering for an AusEinet mental health worker.

The tender process generated a great deal of interest and many worthwhile projects were proposed. The selected agencies each provide different opportunities and challenges in re-orienting to early intervention. The outcomes of their reorientation projects will be evaluated and information disseminated through the AusEinet network.

The following brief description of the projects gives an indication of what each is trying to achieve.

The Hunter Mental HealthService and the NSW Department of Community Services will be collaborating in re-orientation to early intervention. Their aim is to reduce the occurrence of mental health problems in children aged 0-10 years who have a primary care giver with a mental illness, and avoid placement of these children into foster care through abuse or neglect. The project will focus on early intervention in problems such as lack of social skills, interpersonal difficulties and avoidance of relationships with peers. An interdepartmental protocol will be developed to improve the management of mental health problems in this target group. The project is located in the Lake Macquarie area, centred around Newcastle.

Barrington Support Service in North West Tasmania is a school based service which supports children and young people who have mental health problems. Reorientation will focus on early identification of students at risk of serious mental illness and develop partnerships between five pilot schools and local practitioners to address their needs. Awareness of mental health issues and skills in handling them, will be increased through training for specialist staff and teachers.

Careforce Central Queensland is an agency of the Anglican church which covers two regional centres, Gladstone and Rockhampton, as well as an extensive rural and remote area. It currently provides a range of programs to diverse client groups of young people and children. The main challenge will be to achieve reorientation across a large geographical area, parts of which have few mental health resources. Training to increase awareness and improve practices in relation to a range of mental health issues is the main focus of the project. Two levels of training are proposed; one aimed at increasing understanding among a wide range of agency workers and key community people, the other aimed to train people to carry on the early intervention approaches after the conclusion of the project.

Karawara Community Project is a small community based, non-government organisation in the City of South Perth. It is in a low income area with a multicultural population, including refugees and Aboriginal people. The focus of

A particular focus of the workshop for early intervention in indigenous communities. Professor Ernest Hunter addressed this question and Mr Neil McLeod described the importance of community development as a strategy within the Palm Island Mental Health Service. An impromptu presentation by indigenous worker, Ms Mercy Baird, was well received as were the two other presentations by local speakers (Mr Rob Hanlon and Mr Nigel Inskip) on early intervention programs in local high schools. The AusEinet project and early intervention in mental health disorders of children and young people were presented by Associate Professor Graham Martin and Cathy Davis respectively. Cairns ABC radio conducted interviews with Associate Professor Graham Martin both prior to and following the workshop.

As with the Brisbane workshop, a series of small group discussions provided considerable input to the AusEinet project. In particular, contextual issues impacting on mental health and early intervention programs and practices were highlighted. The participants were appreciative of the opportunity to participate in the AusEinet workshop. The constraints, inherent in living in a remote area of Australia, were highlighted. A summary of the findings from the small group discussions can be found on the AusEinet website: http://auseinet.flinders.edu.au.

Kalgoorlie Workshop

In May, the AusEinet project team conducted a workshop with 30 enthusiastic participants at the Mercure Overland Hotel in Kalgoorlie. This workshop had a strong consumer focus, with a number of participants from local consumer groups attending.

In addition to Graham Martin and Cathy Davis from AusEinet, a number of local speakers presented on a range of issues relevant to early intervention. Dr Christine Jeffries-Stokes, a local paediatrician, presented a paediatrician's perspective on early intervention; Ms Jenny McCulloch, a local psychologist working in private practice outlined early intervention strategies, based on her experience working in a number of different organisations, with different target groups, and in different states; Ms Elsie Edwards, described the NTP project: ngunytji tjitji pirni and Mr John Titmus, from Perth, gave a presentation on early intervention in psychosis. Summaries of the speakers' presentations will shortly appear on the AusEinet website.

The small group discussions provided a wealth of information on the challenges facing both professionals and consumers in an isolated mining community. A summary of the findings from the discussions will appear on our website in the near future.

Perth Workshop

The Mercure Hotel in Perth provided a congenial setting for the AusEinet Perth workshop. Ninety one participants attended, representing a range of organisations / agencies and professional groupings. A distinctive feature of the Perth workshop was the interest expressed from a range of local people in presenting at this workshop.

Professor George Lipton, opened the workshop with his presentation on early intervention in mental health disorders. Other local speakers were Professor Rob McKelvey who discussed research in determining the mental health needs of Vietnamese children, Ms Anwen Williams who provided a comprehensive overview on the Triple P program as an early intervention in behavioural disorder, Dr Clare Roberts from Curtin University who described the Aussie Optimism Project, Ms Annette Stewart from the WA Department of Education who discussed mental health issues in schools, and Professor David Hay, who outlined the needs of children with a mentally ill parent.

A summary of the findings from the small group discussions along with materials from the presentations given by Ms Anwen Williams and Professor Robert McKelvey will shortly appear on the AusEinet website.

Darwin Workshop

Tropical Darwin was the setting for AusEinet's May workshop at the Mirrambeena Tourist Resort. Sixty four people from Darwin, Palmerston, Gove and Tennant Creek participated. As with AusEinet's other workshops, a range of issues related to early intervention in children and young people were addressed. In addition to presentations from Graham Martin and Cathy Davis of AusEinet, a number of local speakers addressed participants.

Dr Tricia Nagel from the NT Mental Health Services outlined new directions in early intervention in the Northern Territory. Mr Dean Fraser from Anglicare presented an interesting paper entitled "Intervening - individuals, families and systems". The paper described a program for early intervention with homeless youth (or youth at risk of homelessness). Ms Paula Arnol outlined the YRAP program which intervenes with young women (primarily, indigenous young women).

Two academics from the Northern Territory University provided challenging presentations. Dr Sharon McCallum outlined a research project she is currently undertaking with young indigenous men who have committed sex offences. Ms Lesley Merrett discussed early intervention with child sexual abuse victims / survivors.

We hope to provide summaries of the speakers' presentations (and findings from the small group discussions) on the website in the near future.

A special edition of AusEinetter, focusing on the workshops undertaken by AusEinet will be produced and disseminated in September. In addition to providing information on workshops to be conducted in Adelaide, Newcastle and Sydney in June and July, the newsletter will summarise findings and outcomes from the workshops conducted in each state and territory, including information on early

reorientation is to identify earlier, and manage more successfully, the serious mental illnesses that occur in the children and young people of their community. Improved liaison with related agencies such as mental health and general health services, juvenile justice, education, and youth agencies is a key aspect of the project. Protocols, checklists and resource materials will be developed to assist with identification and management of mental health problems.

Child and Family Services in Launceston will reorient staff working with children and young people with challenging behaviour who have come to the Department as a result of a notification, becoming a ward of the state, or through the juvenile justice system. The aim of the project is to address the therapeutic needs of these children and young people, prevent admission to secure residential facilities or youth detention centre and, wherever possible, maintain the child or young person in their family.

Children of Prisoners' Support Group is a small non-government agency supporting children aged 0-18 years who have a care giver on remand or in custody. Reorientation will enable them to help children and young people who have mental health problems such as anxiety, depression and disruptive behaviour. Links with other agencies, such as the Department of Community Services, and Correctional Services will be strengthened as part of the reorientation.

Southern Public Health and Department of Education aim to realign their agencies' policies and practices in order to deliver early intervention programs in mental health to school children and adolescents up to the age of 17 years. The project will reorient nurses and other staff working within schools to adopt an early intervention approach to mental health problems and improve collaboration in the management of these problems. The project is located in Albany, Western Australia.

The Mildura Aboriginal Corporation is proposing to have staff and community members trained in using *Spiritual Healing* to address the serious mental health issues faced by many of the children and young people in their community. The Corporation, located in Mildura, Victoria, provides services to Aboriginal people in the Sunraysia district.
Pauline Dundas, Project Consultant, AusEinet.

AusEinet Workshops

AusEinet workshops were held in Brisbane and Cairns in March, in Kalgoorlie and Perth in April and in Darwin in May.

Brisbane Workshop

The AusEinet workshop held in Brisbane received an overwhelming response with 196 people attending. Participants (from Brisbane, the Gold Coast, Toowoomba and Ipswich), came from a variety of professional backgrounds: academics, general practitioners, guidance officers from the Education Department, school principals, occupational therapy and social work students, and social workers and counsellors from a variety of organisations including CYMHS, Kids HelpLine, Kinnections and Family Services.

A range of mental health conditions / disorders / issues in children and young people were addressed in terms of the potential for early intervention. These included: the Triple P program (its use as an early intervention program for behavioural and conduct disorders in children - Ms Karen Turner); a parent aide program (Mr Richard Webb, Mater Hospital); early intervention in child sexual abuse (Professor Barry Nurcombe); and evaluation of the Youth at Risk Project (a suicide prevention project - Ms Maria Donald). Additionally, members of the AusEinet project team explored putting early intervention into the mental health of children (Associate Professor Graham Martin) and provided a preliminary report on findings from the literature review and from the national stocktake of early intervention programs. Associate Professor Graham Martin was interviewed by local ABC radio.

Given the large number of participants and the diversity of expertise they provided, the project team was able to obtain considerable input on a range of issues related to the AusEinet project through a series of small group discussions. Key roles of AusEinet were seen as dissemination of material, networking, assistance with reorientation and establishment of best practice in a range of mental health disorders / conditions and issues impacting on children and young people. Information was also provided to the AusEinet project team on early intervention services in Brisbane which aided networking among the professionals present and will assist the project team in the national stocktake process. A number of opportunities, barriers and constraints to the reorientation process were also identified. Further details of the Brisbane AusEinet workshop (including a copy of Professor Barry Nurcombe's presentation) are available on the AusEinet website: http://auseinet.flinders.edu.au

Cairns Workshop

Considerable networking in North Queensland was undertaken by the project team which resulted in 43 participants from Cairns, Atherton, Townsville, Innisfail and Palm Island attending the Cairns workshop on Saturday 14th March. Participants from a range of backgrounds (academics, guidance officers from the Education Department, social workers, nurses and counsellors from CYMHS, alcohol and drug services, domestic violence services and indigenous communities and social work students from James Cook University attended. Despite an unanticipated electricity failure which caused presenters, participants and the project team some anxiety, the workshop was very successful.

Funded under the National Mental Health Strategy by the Commonwealth Department of Health and Family Services

intervention services, gaps in services, and opportunities, barriers and constraints to reorienting services to more of an early intervention focus. Opportunities for future networking will also be explored. The AusEinet project team would welcome your suggestions of strategies to encourage further networking in each of the states and territories.
For further information: Email: auseinet@flinders.edu.au; phone (08) 8357 5788; fax: (08) 8357 5484

Australian Clinical Guidelines for Early Psychosis

The National Early Psychosis Project had as it's mandate to develop and promote best practice in the early detection and treatment of psychotic illnesses. One of the key outcomes for this project has been the development of a set of Clinical guidelines that have been written specifically for the Australian context.

The Guidelines were developed using a collaborative and consultative process taking in the views and experiences of a number of key stakeholders around Australia and then providing via the NEPP State and Territory Coordinator's an opportunity for wider consultation with the Mental Health field.

The Clinical Guidelines have been designed to be easily used by mental health clinicians situated in any number of organisational contexts and make use of a simple yet instructive format to enable clinicians to make full use of the guidelines in their day to day practice.

The Clinical Guidelines take the reader through the models and stages of early psychosis, key principles of intervention , the requirements of specific groups, and issues for service development. Throughout the document case examples are used to demonstrate the guidelines being utilised in a real world setting.

This document can be used by an individual clinician who is wanting to use the information to guide and develop their practice* or can be utilised by those involved in the development of service models, preparation of procedural and policy statements.

It would not have been possible to produce this important document without the assistance of the National Mental Health Strategy which funded the NEPP and asked it to prepare this document as a component of the project.

The Clinical Guidelines for early psychosis are available from the Early Psychosis Prevention and Intervention Centre and more details on how to obtain themcan be provided by faxing the Office Manager of EPPIC Statewide Services on 02 9342 2941.

The Australian Clinical Guidelines for Early Psychosis will be officially launched at the Second Conference on Early Psychosis - Realising the Potential on the 4 & 5 September this year in Hobart Tasmania. If you would like further information about this conference please contact the Conference Secretary at EPPIC on 03 9342 2800.

*Please note this document has been developed as a guide for use by mental health practitioners. The document does not purport to represent the definitive approach to treatment procedures for use with people experiencing early and / or first episode psychosis. The document should be used as a guide and practitioners should use their professional judgment when considering individual cases.

VIDEO AND BOOK REVIEWS

Getting in Early: Helping Young People with Psychosis. "Sally's Story": A Video for Mental Health Professionals

Sally's Story is a 43 minute video which was written and produced by Bernadette Dagg and funded under the National Mental Health Strategy through the NSW Health Department – Centre for Mental Health (NSW NEPP Project). A vignette, 'Sally's Story", is utilised to highlight key principles and major issues surrounding prevention and early intervention. Ms Trish Goddard acts as moderator for a panel comprising Professor Patrick McGorry (Director of NEPP and EPPIC), Ms Agravaine MacLachlan (a Consumer Representative from SA), Ms Vicky Ryan (Team Leader for the Young People's Program, Paramatta) and Ms Deb Howe (Project Co-ordinator YIPPIE-IA – Gosford).

The panel explores key issues for Sally, a 17 year old school student living with her mother and 15 year old brother and experiencing what appear to be prodromal symptoms of psychosis. Principles for working with young people and their families are explored in terms of assessment issues, treatment and the recovery process.

While the issues in *Sally's Story* are of necessity, dealt with briefly, the video does provide the viewer with good, basic principles for working with young people experiencing psychotic symptoms. These include the importance of engaging the young person and listening to their story working with the family, adopting an optimistic approach, and empowering the young person to be in control of their life.
Copies of this video are available from Bernadette Dagg Centre for Mental Health 02 9391 9217 or fax 02 9391 9041 at a cost of $35.00
Nathan, P.E. & Gorman, J.M. (1998) A Guide to Treatments that Work. Oxford University Press: New York

This recently published book provides an excellent and comprehensive review of "treatments that work" for a range

of mental disorders in children and adults. Nathan and Gorman, the editors of this work, endeavoured to encourage contributors to adopt an evidenced-based approach by providing potential chapter authors with brief advisory material for judging the methodological adequacy of the studies on which they were to base their conclusions. They have also provided the reader with an interesting, introductory chapter detailing the history of systematic efforts to identify empirically validated treatments for mental disorders.

Areas covered in the book include schizophrenia (both pharmacological treatments and psychosocial treatments); substance disorder (psychopharmacological treatments); alcohol use disorders (psychosocial treatment); conduct disorder in children (psychosocial treatments); childhood attention deficit hyperactivity disorder (pharmacological treatments and nonpharmacological and combination treatments); bipolar disorder; obsessive compulsive disorder; eating disorders; personality disorders; panic, generalised anxiety and phobic disorders; and post traumatic stress disorder.

The book concludes with a challenging chapter from Seligman, who questions the evidenced-based approach employed.

** Adelaide produced videos win international acclaim **

Communications consultant Marsha Dearden and video director Andrea Hickey have won an internationally acclaimed award for creative excellence in video production at the 31st Annual US International Film and Video Festival, June 3rd in Chicago. Considered to be the world's leading competition for business, television, industrial and informational productions, the festival attracted more than 1600 entries from 28 countries. The award's two-tier judging system, encompassing the industry's most experienced and qualified judges, results in recognition that is truly earned and respected around the world.

Written by Marsha Dearden and directed by Andrea Hickey, the documentaries are part of the *Keep Yourself Alive* suicide prevention package funded by the Commonwealth Department of Health and Family Services under the National Youth Suicide Prevention Strategy.

Entitled "Youth Suicide: Recognising the Signs", "Youth Suicide: Crisis Intervention", "Youth Suicide: Therapeutic Approaches" and "After Suicide: Picking up the Pieces", the videos feature 30 South Australian actors professionals and young people. The development team included Associate Professor Graham Martin, Dr. Paul Beckinsale, and Dr. Sheila Clark.

Adelaide based cinematographer, Aaron Gully, has won awards from the Australian Cinematographers Society for "Recognising the Signs" and "Crisis Intervention".

The audiotapes which form part of the package have won both South Australian and Australian MBF awards, the Catholic Archbishop of Adelaide's ward for media, and were shortlisted for the Peter Grieve Memorial Award (RACGP).

The package has recently been shortlisted in the TAFE and Vocational Teacher Reference Category of the Australian Newspaper Awards for Excellence in Educational Publishing - this award will be announced on June 25th in Melbourne.

The 'Keep Yourself Alive' suicide prevention package (which includes the 4 videos, 2 audios, full day workshop instructions (modular format for up to 4 mini workshops), a comprehensive manual and a colourful poster is available at $285.
Telephone Jill Knappstein on 08 8357 5788 for more information.

AusEinet Database

The AusEinet database is steadily developing. To assist us please complete the following details and forward to AusEinet if you would like to be informed of future AusEinet activities, nationally or in your own State or Territory.

Name: .....

Organisation: .....

Address: .....

.....

.....P/C.....

Telephone:.....Facsimile:.....

Email: .....

Return to AusEinet C/- CAMHS, Flinders Medical Centre, Bedford Park SA 5042. Telephone: 08 8357 5788 Facsimile: 08 8357 5484 Email: auseinet@flinders.edu.au

THE NEXT ISSUE WILL BE PRODUCED IN SEPTEMBER.

DEADLINE FOR MATERIAL WILL BE **FRIDAY 4TH SEPTEMBER 1998**

PLEASE LET US KNOW WHAT YOU ARE DOING. CONTACT AUSEINET WITH SUGGESTIONS FOR TOPICS TO BE COVERED.

AUSEINET WEBSITE ADDRESS
http://auseinet.flinders.edu.au

Funded under the National Mental Health Strategy by the Commonwealth Department of Health and Family Services

AusEinet

AusEinet Website

We are starting a 'chat' site for early intervention in July. If you are interested you will need to forward your email address to auseinet@flinders.edu.au

June, 1998
AusEinet
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ISSN 1329-8720
Issue 5, September 1998 - No 3/98

AusEinetter

Guest Editorial

Professor Ernest Hunter

Early Intervention for Indigenous Social and Emotional Health Problems

Through the last two decades there has been a growing awareness of the social and emotional problems experienced by Aboriginal and Torres Strait Islander Australians. There has also been increasing recognition and acknowledgment of their historical precursors. This has been most forcefully articulated in the report of the Human Rights and Equal Opportunity Commission's (1997) report into the separation of Aboriginal and Torres Strait Island children from their families. Thus far, the main thrust of formal responses has been to extend mainstream mental health services to Indigenous communities. This is commendable if yet far from ensuring equity of access to such services, or cultural appropriateness in their delivery. However, against the burden of antecedent socio-environmental precursors that contribute to undermining Indigenous social and emotional wellbeing, such approaches are clearly important but insufficient.

There is at present considerable discussion of mental health promotion and prevention initiatives in Aboriginal and Torres Strait Islander communities. However, practitioners wishing to shift the focus of activity towards earlier and population-targeted approaches in these populations must resolve for themselves the tensions that exist between social justice demands requiring major social change on the one hand, and the need for pragmatic but limited initiatives on the other (Syme, 1997). Ultimately, while significant improvements will require both, the pursuit of the latter should not be precluded by the lack or slowness of gains in the former.

Within the broad field of Indigenous social and emotional health, five levels of activity may be considered. From a social justice/population level to an intervention/individual level these are: political (reconciliation and social equity); community development (including health promotion and prevention initiatives); appropriate mainstream services; adapted mainstream approaches (such as the adaptation of narrative therapy to Indigenous needs [Aboriginal Health Council of South Australia, 1995]); and, Indigenous therapies (as are being developed in several centres, including We-Al-Li, Rockhampton).

Each of these levels may be relevant to consideration of early intervention. Social justice and community development initiatives are essential to lessening the burden of circumstances and events predisposing to ill-health among Indigenous people; mainstream, adapted and Indigenous therapies all have a place in addressing existing needs. However, the identification of those needs (and thus the capacity for early intervention) is compounded in Indigenous settings by several factors. First, our ability to intervene early to address specific vulnerability rests on our capacity to identify individuals/groups at risk. In many Indigenous communities those factors or conditions indicating risk are experienced universally. Second, even if such individuals/groups are identifiable, intervening necessarily requires that it is seen as a priority by all parties. Particularly in remote settings where many Indigenous people are living in circumstances of unremitting need and adversity, priorities may be very different and far more immediate. Prevention may be a hard sell. Third, case identification and early intervention presumes that basic services are in place to support and sustain such initiatives and to provide basic clinical care as necessary. Ironically, in circumstances such as much of Indigenous Australia where this is not the case, early intervention strategies may have to start with the more fundamental and modest task of establishing functional clinical services.

From the foregoing it should be clear that there are many tensions and contradictions in this area of work. On the one hand, the extent of social disadvantage in Indigenous communities and the consequent universality of risk experience in those communities suggests the importance and logic of prioritising universal rather than selected or indicated preventive interventions (targeting the population rather than groups or individuals at risk). On the other

Funded under the National Mental Health Strategy by the Commonwealth Department of Health and Family Services

hand it is questionable whether early intervention is possible at all in the absence of functional basic services, suggesting that the development of such services should be an urgent priority.

Of course, in reality it is not 'either/or' but both. Non-Indigenous mental health professionals may contribute to the wider project of Indigenous social and emotional wellbeing by collaborating with Indigenous groups developing specific innovative programs aiming at prevention and early intervention. They may also contribute by working towards providing Indigenous Australians with equitable access to appropriate and effective clinical services. Both will be of limited potential in the absence of the other and, accordingly, neither should be prioritised at the expense of the other. Reflecting back on Syme, it is about the grand sweep of social justice and the narrow focus of targeted projects. Each has its place but neither should be neglected.

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Guest Editorial

Ms Penny Mitchell

Early intervention: its place in the prevention of youth suicide

As part of the Communications Project of the National Youth Suicide Prevention Strategy, the Australian Institute of Family Studies has recently completed a national stocktake of youth suicide prevention activities. Information on over 900 projects throughout Australia has been collected and entered into a database. This article provides a content analysis of information from the Stocktake database about projects that adopt an 'early intervention' approach to suicide prevention.

Identifying and describing the range of 'early intervention' activities in the Stocktake database is largely an exercise of exploration and discovery. However, as in explorations and investigations of any kind, what we are able to 'discover' will always be constrained by the preconceptions we have about what we are looking for. In overcoming or seeing past these constraints it helps to try and be clear about what our preconceptions are.

The concept of early intervention in youth suicide prevention

The National Youth Suicide Prevention Strategy (NYSPS) has involved a comprehensive variety of approaches to the persisting high rate of suicide among young people in Australia. Ways of thinking about these various approaches are evolving as the current Strategy enters its later stages and as information becomes available about the process of project implementation.

When the NYSPS was initiated the following direct approaches to prevention were identified in the major policy document (CDHFS 1997):

- Injury prevention;
- Primary prevention and cultural change;
- Crisis intervention and primary care;
- Support and postvention;
- Community development and support;
- Indigenous, specialised and culturally diverse.

One of the steps I took in analysing the data from the National Stocktake of activities was to categorise each of the direct prevention projects (as opposed to projects that operate at a broad system level) into one (and only one) of these main prevention approaches (except 'Indigenous, specialised and culturally diverse' which was incorporated into a separate field for target population). This was not always an easy task and there was one important area of particular difficulty. I kept finding projects that were clearly oriented towards intervening as early as possible in emerging problems that could place young people at risk of suicide in the future. These projects did not fit into any of the five categories identified in the policy document so I created a new category of early intervention.

But what do I mean by early intervention? The categorisation system above (even an extended one) is problematic in attempting to answer this question. We might be able to clearly distinguish early intervention from primary prevention but there is quite a lot of overlap between early intervention and concepts such as 'primary care' and 'community development'. Primary health care services are (or should be) a key setting for effective early intervention and community development is a key strategy for expanding the network of people who can play a role in identifying young people at risk and facilitating their early access to appropriate help. Concepts such as early intervention, primary care and community development do not actually belong in the same conceptual system. Early intervention is an approach to suicide prevention while primary care is a setting and community development, a specific activity or intervention.

At a recent meeting of the expert panel which is providing advice to the Australian Institute of Family Studies in the conduct of the National Communications Project of the NYSPS there was general agreement that the most useful and up-to-date concepts for describing approaches to suicide

prevention are: (1) the public health concepts of primary; secondary and tertiary prevention (Commission on Chronic Illness 1957 cited in Mrazek & Haggerty 1994) which refer to the stage of development of disorder in affected populations; and (2) the concepts of universal; selective and indicated prevention (Mrazek & Haggerty 1994), more familiar in mental health circles, which refer to the population groups targeted.

For the sake of simplicity I have chosen to use the public health framework of primary, secondary and tertiary prevention in the present exploration of early intervention projects. Further, for the sake of clarity I have placed early intervention firmly within the realm of secondary prevention.

Secondary prevention is concerned with lowering the prevalence of problems or disorders in the population (Mrazek & Haggerty 1994). Secondary prevention includes intervening when risk factors are detected to prevent or delay the onset of disorder (or the outcome being prevented) and intervention in the course of an emerging problem/disorder with the aim of shortening its course or preventing its recurrence. In the context of suicide prevention, secondary prevention involves intervening early when risk factors for suicide have emerged or are emerging to prevent the onset of suicide related behaviour. Secondary prevention occurs before suicide related behaviours emerge. Once suicide related behaviours have emerged, intervention is by definition, within the public health framework, tertiary prevention. Primary prevention of suicide involves preventing the development of proximal (also referred to as second-order or person-level by Silverman & Felner 1995) risk factors for suicide.

The term 'early intervention' also clearly implies an element of selectivity, and perhaps, specificity, in terms of who interventions should be directed towards. Thus the concepts of 'selective' and 'indicated' prevention as defined by Mrazek & Haggerty (1994) are clearly very useful here. This suggests that a precise definition and understanding of the place of early intervention in the spectrum of interventions may require a framework that utilises the insights of both the established frameworks, in relationship with each other.

Mrazek and Haggerty (1994) have rejected a framework that blends or integrates these contrasting conceptual systems and here is not the proper place to attempt full explication of an integrated framework that might be appropriate. Suffice it to say that Mrazek and Haggerty reject this integration in the context of presenting a framework for understanding prevention of mental disorders and we are talking here about prevention of suicide related behaviours, for which mental disorders are but one risk factor, albeit a most important one. It is mainly for this reason that I prefer not to use the intervention framework provided by Mrazek & Haggerty (1994). I do, however, occasionally borrow the terms 'selective' and 'indicated' because I find them useful words although there is a risk of using them in ways and places that Mrazek and Haggerty might disapprove of.

Early intervention: Information from the National Stocktake of Youth Suicide Prevention activities

The first National Stocktake collected data on over 900 projects. This includes 65 projects funded under the National Youth Suicide Prevention Strategy (NYSPS).

A total of 85 projects are included in this analysis of early intervention projects. These include 59 projects where early intervention is identified as the main prevention approach and a further 26 that were categorised as belonging to other prevention approaches but included a strong focus on early intervention strategies. Only 5 of the 85 projects are NYSPS funded projects.

Projects are included in the category of early intervention if they belong to the domain of secondary prevention and included an element of proactive case finding or other mechanisms for enhancing early identification of candidates for intervention.

Projects that involve treatment or intervention with clearly established disorders or problems that did not also include evidence of an element of proactive case finding or other mechanisms for enhancing early identification were not included in the category of early intervention. This is a conservative application of the definition of early intervention as secondary prevention. From the information provided in the Stocktake it is often very difficult to discern whether projects are intervening only before the onset of suicide related behaviour ('indicated prevention' at the risk of misusing Mrazek and Haggerty's term) or whether they were also including individuals who had developed these behaviours (tertiary prevention). In reality the populations targeted by many services are very mixed and include young people who have and have not developed self-harm and suicide related behaviour without making clear distinctions between them. A conservative approach was adopted in the present analysis in an attempt to minimise inclusion of projects that were primarily tertiary prevention.

In the present analysis it is also important to distinguish early intervention from primary prevention. Thus selectively targeted primary prevention has not been included as early intervention.

Data from the 85 early intervention projects were organised according to two further fields: target group and organisational setting.

Early intervention projects were focused on five major target groups: (1) the general population (n=9); (2) students (n=26); (3) young people exposed to a wide range of general risk factors (n=14); (4) young people with emerging or early stage mental health problems (n=21); and (5) young people belonging to other particular high risk groups (n=15) eg homeless, Aboriginal and Torres Strait Islander, involved in

the justice system, males, victims of sexual assault, bereaved by suicide.

Projects targeting the general population

These projects were being conducted by four types of organisations: community organisations (n=5); Divisions of General Practice (n=2); a Public Health Unit (n=1); and a Family/Parent/Child Service (n=1).

The main strategy employed by early intervention projects targeting the general population was community education aimed at enhancing community awareness of mental health and youth suicide issues. Community education was explicitly aimed at enhancing community members' ability to identify young people at risk and assist them to access appropriate help for any problems they may be having. In other words the aim was to enhance early intervention.

In addition to community education, Divisions of General Practice were promoting the development of networks between general practitioners and other service providers and providing training to their members in the identification, referral and management of young people at risk.

Projects targeting students

A wide range of organisations were involved in projects targeting students. The main types of organisation were: schools (n=13); community organisations (n=2); youth services (n=2), a Child and Adolescent Mental Health Service, a Community Mental Health Service, a Police Service, a University, a Community Health Service, a Family/Parent/Child Service and a Professional Association.

Activity in schools was focused on establishing systems for identifying students experiencing problems that could place them at risk of suicide and ensuring that they are provided with appropriate support such as counselling or referral to other services. These systems tended to involve policies and procedures as well as definition of clear roles for staff. Some systems included all staff while some included only certain designated staff.

The other major area of activity in schools is provision of education to students (and to a lesser extent, teachers) about mental health, mental illness, suicide and helping strategies. As with education provided to the general population the aim is to enhance the capacity of young people to identify problems in themselves and their peers in order to facilitate access to appropriate help.

A smaller number of schools were implementing secondary prevention programs selectively targeted at young people identified as being at risk. These included personal/life skills groups and coping with depression groups.

Projects conducted by other organisations targeting students were similar to those based in schools. Provision of education about mental illness, suicide, how to seek help as well as identification of individuals at risk were major activities. There were also two projects targeting students at risk of school drop out.

Projects targeting young people exposed to a wide range of general risk factors

These projects were based in a very wide variety of organisational settings. These included: youth services (n=3); Child and Adolescent Mental Health Services (n=2); Police Services (n=2); Community Health Services (n=2); universities (n=2); a community organisation (n=1); a religious organisation (n=1); a government department (n=1); a Community Mental Health Service (n=1); and a Division of General Practice (n=1).

As with projects targeting the general population and students there was a strong focus on activities which aimed to identify or facilitate identification of young people at risk. The main strategies in this regard were community development and community education aimed at enhancing the capacity of community members to identify and assist young people at risk. Another important strategy was development of interagency networks to enhance referral processes and collaboration. A few services were also providing training to providers in other services aimed at assisting them identify young people at risk.

On the intervention side, several services were providing counselling and general support to marginalised young people. One youth service was also providing group based programs in schools and a Child and Adolescent Mental Health Service was providing a life problem solving skills group targeting young people who were presenting with a wide range of behaviour and social problems. A program based in a university focused on developing resilience and other skills for coping with depression and anxiety. A Police Service was conducting five day camps with young people identified as at high risk of becoming involved with the justice system. The aim was to build self esteem, self discipline and responsibility through character building and challenging activities.

A particularly innovative project was reported by a Division of General Practice which involved developing a one stop 'drop-in' primary health service dedicated to providing a highly accessible and comprehensive health service culturally appropriate for marginalised young people who have difficulty accessing other services. This service also provided a range of personal development and life skills groups for young people at risk.

Interventions with this target group had a tendency to take the form of outreach. Outreach bridges both active case finding and intervention in that it brings services out to marginalised young people in the places they inhabit rather than waiting for them to seek help from traditional centre-based service. Outreach was explicitly mentioned as being practiced by a youth service and one Child and Adolescent Mental Health

Service. Activities by several community organisations such as youth clubs and can also be considered a form of outreach, especially when linked to appropriate specialist services, because they provide critical ongoing support to many marginalised young people who lack access or may be reluctant to approach other services on their own.

A number of project descriptions mentioned the importance of a multisystemic approach to intervening with young people exposed to multiple risk factors. These projects were intervening in a number of systems such as family, school, health, welfare and the justice system in order to provide a holistic approach to the complex problems affecting highly marginalised young people.

Projects targeting young people with emerging and early mental disorder

Activities in this category were being conducted entirely by mental health services, primarily Child and Adolescent Mental Health Services (n=10); Community Mental Health Services (n=6); and integrated Area/Regional Mental Health Services (n=4). Very similar activities were being conducted in these different types of mental health service. They will therefore be discussed together.

Twelve of the 21 projects in mental health services were early psychosis programs. Only four of the 21 targeted other specific mental disorders. For other projects no particular diagnostic group was mentioned as being targeted. Six projects, including some of those that targeted particular mental disorders, had a special focus on identifying and responding to young people with mental disorder who are at particularly high risk of suicide or self-harm.

By definition all these programs were proactively seeking to identify cases and enhance access to services. A popular strategy for case finding was networking with other services to facilitate referral by those services. One project was providing training to primary health care professionals in the identification of emerging mental disorder and appropriate responses.

A much smaller number of mental health services indicated that they were using strategies such as community outreach and community education to promote broad awareness of their service among young people and families.

Young people belonging to other specific high risk groups

Projects in this category included those targeting young people who are: homeless or at risk of homelessness (n=6), of Aboriginal and Torres Strait Islander background and/or culturally diverse (n=4), involved in the justice system (n=2), males (n=2); victims of sexual assault (n=1), bereaved by suicide (n=1).

The types of organisations and the broad types of interventions being directed to young people in these specific high risk groups were largely similar to those described in the section on *Projects targeting young people exposed to a wide range of general risk factors*. Indeed many of the young people targeted by projects in this category have exposure to a range of risk factors. Projects targeting specific risk factors are described separately here because they offer an opportunity to learn more about ways of tailoring interventions to specific needs. Reporting will focus on these specific differences.

Homelessness The projects targeting young people at risk of homelessness included interventions to help them reconcile with families and help families gain access to other services that can support them through the difficulties that threaten to break the family. Interventions with homeless youth included provision of accommodation, counselling and general support, assistance with family reconciliation and advocacy to assist access to schools, health services and income support. One of the projects targeting homeless youth had a special focus on identifying warning signs for self-harm and suicide related behaviour and putting in place strategies to prevent suicide.

Aboriginal and Torres Strait Islanders One of these projects focused on providing training to a variety of professionals to develop their skills in working with Aboriginal and Torres Strait Islander youth at risk of suicide. Another project involved a systemic approach to identifying ATSI youth with early warning signs and developing interventions. A third project included the ATSI community as one of several groups in a comprehensive multicultural community and professional education program regarding youth suicide issues.

Justice system Early intervention projects targeting young people in the justice system included a diversionary program and a program that teaches cultural awareness to Aboriginal young people.

Males Projects targeting males included an 8 week aggression management program for young men who are beginning to act out with violent behaviours and a community education seminar on men's health that included a focus on how to help other men seek help if suicide arises as an issue.

Other A project in a sexual assault service provided community and professional education about sexual assault issues including the suicide risk associated with being a victim of sexual assault. The aim was to enhance service responses to young people affected by this risk factor for suicide. A Child and Adolescent Mental Health Service was running a support group for young people who had experienced a suicide in their family and who were judged to be at risk themselves.

Discussion and conclusion

In this analysis, early intervention is defined as belonging to the category of secondary prevention, which is concerned with intervening when risk factors or early signs of disorder have

emerged in order to prevent or delay the emergence of the outcome being prevented (ie suicide related behaviour).

Early intervention in youth suicide prevention involves two essential types of activity: (1) identification of young people with elevated risk for suicide related behaviour (early identification) and (2) intervention to interrupt the process (trajectory) whereby risk factors or early signs may lead to the development of the outcome being prevented.

Early identification

The analysis revealed four main types of activities belonging to the category of early identification. These were:

- Education of community members in mental health, mental illness and suicide issues to enhance their capacity to identify signs of risk and direct young people at risk to appropriate help. This type of intervention has been labelled as "Gatekeeper Training" (Potter, Powell & Kachur 1995). This type of community education was also being conducted in schools, targeting students and teachers.
- Networking among a diverse variety of service providers to facilitate the referral, or smooth the pathway, of young people to appropriate services and seal gaps in the system.
- Establishment of other formal systems (eg in schools) for identifying and referring young people identified as being at risk.
- Education of primary health care professionals in the identification of young people at risk.

Intervention

The data reported here suggest that early intervention in suicide prevention is different from other types of intervention (eg traditional treatment of mental health problems) in several key respects:

- *Target groups are highly diverse* and individual members of target groups are often exposed to multiple risk factors for suicide. This indicates the value of multisystemic interventions that are appropriate to the complex problems of the target groups. The diversity of problems affecting the target group underlines the importance of supporting the involvement of a diverse variety of services and other organisations in comprehensive and coordinated approaches to early intervention. In other words, enhancing interagency collaboration would appear to be critical.

- *An emphasis on intervening as early as possible*, combined with the marginalised existence of many of these young people indicates the need for interventions that are oriented towards outreach, that is, interventions that are conducted in the places where young people at risk are going about their lives. The importance of outreach in effective early intervention is underlined by the potential to combine identification and intervention activities to enhance cost-effectiveness. Outreach is probably a relatively underdeveloped aspect of early intervention in youth suicide prevention compared to other types of centre-based intervention. Venues where such outreach is currently occurring include schools, youth services and a range of community organisations. There appears to be a relatively low level of outreach activity by mental health services.

It might be argued that direct outreach by mental health services (especially that aimed primarily at early identification) could be a prohibitively expensive strategy for services that are currently struggling to address current levels of demand for centre-based services. However issues of equity in access to services for disadvantaged and marginalised young people arise here. Highly cost-effective outreach might be achieved in a de-facto manner by enhancing collaboration between mental health services and other organisations involved in direct outreach to young people. Early interventions directed to selected groups of young people in their usual work and recreational environments (eg schools and youth clubs) could also prove more cost effective than centre-based individually focused interventions in the long term.

Limitations of the present analysis

The major limitations concern: (1) the representativeness of the Stocktake database with regard to the actual range of youth suicide prevention activities taking place nationally; and (2) the representativeness of the 85 projects selected for this analysis of early intervention projects in comparison with the range of projects in the database that could have been included.

Representativeness of the Stocktake database

The projects in the Stocktake database constitute a sample of current activity and it is unclear to what extent this sample is representative of the full diversity of activities. For example, information from the database suggests that there is a very low level of focused youth suicide prevention activity in key areas for early intervention such as the juvenile justice system and drug and alcohol services. It is difficult to determine whether this is an accurate reflection of reality or whether these areas were poorly sampled in the data collection process.

Representativeness of the early intervention sub-sample

The present analysis is probably underinclusive with regard to the number of projects in the Stocktake database that could be considered to involve early intervention. For instance projects that were categorised as 'Crisis intervention and primary care' and 'Community development and support' under the field of 'Main prevention approach' were excluded from the present analysis unless they were also categorised as including 'early intervention' as one of the three 'Main interventions/activities' that they were implementing. It is possible that a substantial number of these projects involved early intervention as one of their main interventions but that this emphasis was more subtle and thus obscured by the more explicit prominence of other types of interventions.

The second National Stocktake will seek to overcome some of these post-hoc coding problems by asking respondents to clearly identify three key interventions/activities and a main prevention approach that they believe best describe their program.

These coding problems also reflect one of the problems with the original conceptual framework used to categorise projects funded under the National Youth Suicide Prevention Strategy and suggest the need for further work aimed at reaching broad agreement about an appropriate conceptual system for Approaches to suicide prevention. Such a system will need to have conceptual integrity with regard to the dimensions used to characterise or define approaches to suicide prevention. For instance I would argue that it is inappropriate to include multiple dimensions such as settings (eg primary care), target groups (eg indigenous), and specific interventions (eg crisis intervention and community development) within a single conceptual framework for defining approaches to suicide prevention. A framework with conceptual integrity must employ one or perhaps two concepts only, which in combination define each and every category within it.

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Definitions (World Health Organisation)

Suicide: Death from injury, poisoning or suffocation where there is evidence, either explicit or implicit, that the injury was self-inflicted and that the dissident intended to kill himself or herself. (The term completed suicide or death by suicide can be used interchangeably with the term suicide).

Suicide attempt: A potentially self injurious behaviour with a non-fatal outcome for which there is evidence, either explicit or implicit, that the person intended at some level to kill himself or herself. A suicide attempt may or may not result in injuries.

Suicide related behaviour: Potentially self injurious behaviour for which there is explicit or implicit evidence either that a person intended, at some level, to kill himself or herself, or, that a person wished to use the appearance of intending to kill himself or herself in order to attend some other end. Suicide related behaviour comprises suicidal acts and instrumental suicide related behaviour.

For further information contact Penny Mitchell Research Officer attached to the National Youth Suicide Prevention Strategy Communications Project based at the Australian Institute of Family Studies, Melbourne.

AusEinet: Stream II Reorientation Placements

Under Stream II of AusEinet, we have funded the placement of mental health workers in eight agencies across Australia. The mental health workers' task is to implement and assess the viability of reorientation to early intervention within their agency. A great deal of progress has been made over the last couple of months. All the mental health workers have been employed attended an orientation session and taken on, with admirable enthusiasm, the challenging task of reorienting their agency to early intervention. The agencies were described briefly in the last issue of AusEinetter, but here is a quick reminder:

- *The Mildura Aboriginal Corporation* Mildura, Victoria
- *The Hunter Mental Health Service & NSW Department of Community Services* Newcastle NSW
- *Barrington Support Service*, Devonport North West Tasmania
- *Children of Prisoners' Support Group* Sydney, NSW
- *Anglicare* Rockhampton, Central Queensland
- *Karawara Community Project* Perth, WA
- *Child and Family Services* Launceston, Tasmania
- *Southern Public Health and Department of Education* Albany, Western Australia.

The mental health workers met with me in Sydney recently for an Orientation Session. The session was timed to coincide with the AusEinet Workshop (22 July) and the Third Child & Adolescent Mental Health Services Conference (23-25 July). This allowed the mental health workers to meet formally (twice) and informally (often – this group understood the concept of having a good time) over a period of several days. They were also able to benefit from the stimulating environment of the conference and make contact with others working in the field of young people's mental health.

In preparation for the Orientation Session, all received a handbook which contained information on the AusEinet project, a description of each of the placements, a set of preliminary readings, an agenda for the session, a list of preparatory tasks and a preliminary CAMHS conference program. The objectives of the session were to:

- promote a sense of cohesion and common purpose among the mental health workers
- discuss definitions and practical applications of early intervention

- clarify the role of the AusEinet Mental Health Worker
- clarify the formal requirements of the placement, with emphasis on evaluation and reports
- explore mechanisms for maintaining contact, seeking information and dealing with problems
- place the Stream II placements within the context of the AusEinet project as a whole.

The orientation session was a great success. The mental health workers completed evaluations of the orientation session and of the overall orientation trip (orientation, workshop and conference) and their responses were overwhelmingly positive. They found the set of readings, the description of placements and the opportunity to meet each other and the AusEinet team particularly valuable. All agreed that the workshop, orientation session and conference were valuable sources of information on 'Early Intervention' and gave them ideas which they could use in their placement. Overall, the mental health workers considered the orientation trip to be worthwhile for relieving anxiety about the task ahead, meeting each other, developing ideas, clarifying thinking, increasing confidence and providing opportunities for networking.

The mental health workers have spent the first phase of the placement investigating opportunities for and barriers to early intervention, familiarising themselves with their agency's policies and identifying the education and training needs of the staff. It's a little early yet to report specific achievements, but progress will be reported regularly via the AusEinet website and future issues of AusEinetter.

For information on Stream II activities and contact numbers for any of the agencies, contact me via e-mail aohanlon@health.adelaide. edu.au or phone (08) 8204 6802.

Anne O'Hanlon, Senior Project Officer

AusEinet: Stream III Report: Promotion of Good Practice in Early Intervention

The aim of Stream III of AusEinet is to identify and promote good practice in early intervention. To achieve this we are:

- commissioning specific good practice guidelines (in a range of mental health disorders and contexts) from established research groups;
- funding a range of projects which are likely to make a significant contribution towards the development of good practice.

The commissioning process is currently under way and will be reported in the next issue of AusEinetter. The projects have been selected and preliminary work has commenced on them. The standard of the applications was generally very good, making it a very competitive selection process. Here is a brief description of the six successful projects:

Handbook for working with Indigenous people

Pat Dudgeon, Harry Pickett and Kaleil Merren, Curtin University of Technology, Western Australia

The handbook is a practical guide for psychologists and associated mental health professionals. It addresses the practical issues of working in indigenous settings and with Indigenous people in urban, rural and remote environments. It covers individual, family and community approaches and describes appropriate models of intervention for children, youth and adults.

The handbook is substantially under way and is a collaborative endeavour between the Curtin Indigenous Research Centre, the Centre for Aboriginal Studies and the Australian Psychological Society. AusEinet will fund an evaluation of the handbook and contribute to the cost of printing to help ensure maximum distribution.

Behaviour management of disruptive behaviours in young children with developmental disability

Associate Professor Stewart Einfeld, UNSW and Professor Bruce Tonge, Monash Medical Centre VIC

Only about ten percent of intellectually disabled children with emotional or behavioural disturbance currently receive treatment for these behaviours. In the absence of effective intervention, these children tend to become adults with disruptive behaviours. This study aims to develop cost-effective and scientifically proven early intervention for children aged 3 to 8 years.

The project will assess the outcomes of two behaviour management approaches - Parent Training (in which parents are equipped with knowledge and skills in behaviour therapy) and Differential Reinforcement (in which therapists work directly with children to reinforce pro-social behaviours to expand the behavioural repertoire of the child).

Early intervention with physically abused children and their caregivers

Dr. Richard Bryant and Dr. Karen Salmon, University of New South Wales

Maltreated children typically evidence poorer adaptation than non-maltreated children in many areas of functioning and are likely to retain memories of their experiences over very long periods of time. The longer the individual continues along a maladaptive life course, the more difficult it is to reclaim a normal trajectory. This study focuses on physically abused children aged 4 to 7 years and their caregivers.

The project will evaluate the outcome of two management programs - Parent Child Training (in which children and caregivers are taught cognitive behaviour and communication skills) and Supportive Counselling (in which equivalent amounts of time are spent with the child and caregiver without specific therapeutic intervention). It is expected that the project will provide an empirical basis for directing

optimal management of maltreated children and contribute to good practice in early intervention.

Evaluation of a brief intervention for substance abuse in early psychosis
Professor John Saunders and Associate Professor David Kavanagh, University of Queensland
At least half of the people diagnosed with early psychosis have associated substance abuse problems. However, services often miss people with dual problems because of inadequate screening methods. By identifying these people and intervening early it may be possible to avert further episodes of mental disorder in this group and help them function more effectively in the community.

In this study, which involves several hospitals, inpatients with early episode psychosis will be screened for substance abuse. A random half will receive standard care. The other half will be offered a brief intervention called *Start Over and Survive!* which aims to help participants examine the sequelae of their substance use and develop strategies to reduce its negative impact. The treatment approach is designed to become a standard part of mental health service delivery.

Preventing double trouble – targeting early intervention for refugee children and youth
Ms. Eileen Pittaway and Professor Derek Silove, University of New South Wales
When the trauma suffered by refugee children and young people is not acknowledged and addressed, the young people are left vulnerable to secondary trauma and breakdown in their mental health. This has wide reaching consequences for the young people themselves, their immediate families and society as a whole.

The project will provide a range of materials suitable for a broad range of mental health professionals, service providers and refugee children and young people. The materials will include a compendium of early intervention strategies as well as brochures, comics and games which contextualise the young person's experience and provide information about available services.

Early intervention with infants of parents with a mental illness
Associate Professor Bryanne Barnett and Dr. Nick Kowalenko, NSW
Infants of parents with mental health problems are at increased risk for a variety of behavioural, emotional, cognitive and physical difficulties. These difficulties may be of brief duration, but commonly persist and may result in transmission of the problems into the next generation. Early intervention to enhance parenting skills, parenting confidence and better infant outcome is, then, a matter of significance for the whole community.

The project will result in practice guidelines for the prevention, identification and management of mental health problems for infants and family in the perinatal period (conception to 24 months). The guidelines will be aimed at professionals as well as non-professionals.

The projects are due for completion in March / April 1999 and the commissions should be completed in February / March 1999. Together, they cover a very broad range of mental health disorders and contexts. We're keen to share the outcomes as they emerge and will keep you updated via this newsletter and the AusEinet website.
For further information on Stream III activities, please contact me via e-mail aohanlon@health.adelaide.edu.au or phone (08) 8204 6802.
Anne O'Hanlon, Senior Project Officer

The AusEinet Conference...

An Inaugural National Conference on Early Intervention in Mental Health, tentatively titled

"Risk, Resilience and Results"

will be held on June 6th - 8th, 1999 at the Adelaide Convention Centre.

We anticipate that a number of international speakers will participate (Dante Cicchetti, Dr Patricia Mrazek and Dr David Mrazek have been invited). We also hope that many members of our network will be able to participate in our conference. The purposes of this conference are to display many of the deliverables of the AusEinet project (including AusEikits and AusEitraining resources), to showcase early intervention programs, to explore issues of sustainability of the network, to discuss reorientation issues, to investigate opportunities for ongoing networking, to provide further information on early intervention practice models and strategies and to generate further momentum for change.

Further information on the conference will appear in the next issue of AusEinetter. Please register your interest with the Secretariat, SAPMEA Conventions, 68 Greenhill Road, Wayville, 5034. http://www.sapmea.asn.au\auseinet.htm

APFAM Asia Pacific Forum for Families

This article is to introduce Asia Pacific Forum for Families (APFAM) which was launched in Jakarta in 1997 at the International Council on Social Welfare (ICSW) conference.

The vision of APFAM (International) is "for a group of non-government and government organisations in Asia Pacific countries to work together on development of policy, services, practice and professional issues as these relate to

families and relationships among family members. This establishes a regional base around family and family relationships issues." Member countries include Australia, Malaysia, Fiji, Indonesia, Thailand, New Zealand, and Vietnam. Ms Helen Disney (Chief Executive Officer Relationships Australia National), is the elected President of APFAM (International). Ms Disney is leading the development of a research project which plans to involve all member countries and will explore the impact of global and regional social and economic trends on families in the Asia Pacific region. The project report will be presented to the United Nations Family Unit's Report to the World Social Development Commission in the Year 2000.

Each member country of APFAM is establishing a national Branch to progress further the aims of APFAM International. APFAM (Australia) held a conference in Sydney 24th and 25th August entitled "Asia Pacific Forum on Families - Will Australia's involvement make a difference?" The aims of APFAM Australia were identified by Dianne Gibson (Executive Director, Family Services Australia) President APFAM (Australia). "The current economic downturn in our Region, which has crystallised since the inception of APFAM, will certainly add to the pressures on families. APFAM Australia is keen to promote discussion of social policy initiatives that can strengthen opportunities and services for families. In Australia, there is a close and evolving partnership between non-government family service providers and government funding bodies and we look forward to exchanging our experiences with our Australian and Regional colleagues. We particularly look forward to an exchange of ideas about professional practices and learning across cultures to enhance service delivery to the diverse Australian community and to better understand the challenges to family service provision across the Region."

The conference was opened by the Federal Attorney General the Hon. Daryl Williams, who congratulated those who had worked together to build APFAM and commented upon the successful working partnership which has been forged between non-government and government representatives in the development of APFAM.

APFAM (International) provides an excellent forum to address family, child youth and community issues. The Attorney General noted that members of APFAM include senior government and non-government representatives from 13 member countries. The participation in the APFAM Australia conference of many of these people demonstrated the value and the feasibility of countries and cultures working together towards a community which supports families and children.

At the conference the Attorney General announced the launch of APFAM Journal which will be published by APFAM and La Trobe University Regional Social Development Centre. The aim of the Journal is to encourage an exchange of research and practice information in relation to Child and Family Issues in the Asia Pacific Region to assist the development of best practice. There are many common issues in relation to families and children which all countries are attempting to address. This journal will provide the opportunity of sharing knowledge on how these issues are addressed across the Asia Pacific region. It is intended that this dissemination of knowledge will encourage joint research projects across the regions, encourage the establishment of partnerships amongst non government welfare organisations to share programs of service delivery, and inform policy development.

The Editor of the Journal is Margarita Frederico, Department of Social Work and Social Policy, La Trobe University Bundoora 3083. E-mail M.Frederico@latrobe.edu.au., from whom further information on the journal and guidelines for submission of articles can be obtained.
Enquires re APFAM should be directed to APFAM Secretariat PO Box 51, Yarralumba ACT 2600, e-mail apfam@enerstrat.com.au

"Is There Anybody Out There?"

A Comic and Information Booklet for Young People whose Parents have a Mental Illness

Community Focus is a non-government-organisation on the Sunshine Coast that auspices one of the nine Community Development Projects for Mental Health unique to Queensland. Community Focus strives for honest and equal partnership with consumers of mental health services through: a 50% vote on the management of the organisation for members of the associated Consumer Action Group, the Focus Group; consumer membership on the management committee and taking direction for the program from the Focus Group. The Focus Group which has a large and fluid membership of consumers sets direction for the program and initiates and implements projects and programs. The comic and information booklet for young people whose parents have a mental illness is one such project.

The idea to develop something in a format that would be appealing to young people and also answer their serious questions and concerns about mental illness arose from members of the Focus Group who had teenage children. Several of the young people agreed to work with the Community Development Worker and their parents to help other young people in similar circumstances. The comic book was their idea and is based on their actual experiences with the information pages seeking to address their most serious concerns. The young people had final approval of script and design. The artwork and graphics were done by another Focus Group member.

The children who live in families affected by mental illness suffer difficulties that may have profound effects on their development. Until very recent times they have been largely

ignored by the system. Their childhood may be lost as they grapple with deep turmoils, fears and responsibilities that most adults never have to deal with. Sometimes they are forced to take on the role of primary caregiver and thus miss out on their own nurturing. Guilt and shame can become constant companions.

Although the parents of the young people we spoke to assured us that they had explained their illness to their children many times, our experience was that the young people had not heard or at the very least not understood these explanations. From the ages of eleven or twelve upwards a need to understand mental illness, their role in the family and most importantly the potential for it to enter their own lives had become increasingly important.

"Is There Anybody Out There?" seeks to answer some of the burning questions including "Is it my fault if mum/dad gets sick?", "Will I get a mental illness?" It is envisaged that the booklet will promote communication in the family and encourage the development of a network support plan as all too often these young people are isolated, and ashamed and seek to solve difficult issues alone. The booklet also seeks to dispel guilt and maintains that responsibility should not rest on the child's shoulders.

This booklet does not attempt to provide all the answers but rather to gently and unobtrusively bring the issues to the foreground, provide some explanations, allay some fears and provide young people with options for support. There is an urgent need for support structures and specific services responses for this sadly forgotten target group who so often suffer alone in silence.

We hope that this publication is one small step in creating further awareness of the urgent needs of young people living with a parent with mental illness.
The comic booklets are free with only the cost of postage attached and are available from Community Focus on phone 07 5479 3558, fax 07 5479 3585, PO Box 1330, Maroochydore, Qld, 4558.

Consumer Conference Shapes Up For October

Darren Cocks reports on planning for the second Our Lives Our Choices Conference.
Our Lives our Choices II (OLOCII) is, we believe, the first fully consumer-run mental health conference not merely in Australia but (we think) the entire world. Way to go, Southern Australian mental health consumers! At least those who got the thing up and running. Maybe this conference will show the world the way to go, and other consumer-run conferences will begin, mushroom-like, springing up all over the globe. Consumers of the world unite! You have nothing to lose but those invisible chains of stigma and inequality. OLOCII is, at least in part, about consumers standing up and being counted, and making a difference.

Aims/Philosophy
The Our Lives Our Choices II conference is about breaking down barriers. It is about, in a positive and creative way, consumers tearing themselves free of the cages of bigotry and prejudice within which many of those with the diagnosis of a mental illness live. Mental illness carries a heavy burden of stigma. Even within the mental health 'community' there exists division and destructive rivalry. OLOCII is about bringing those of us who suffer a mental illness, us who have difference, together with those who often purport to be and sometimes actually are our healers - psychiatrists and psychologists.

It is about bringing in the Aboriginal community, a group marginalised with respect to psychiatric treatment as in so many other areas. It is about bringing in, not 'alternative' therapies - a term which I feel connotes exclusivity and division - but 'complementary' therapies, treatments which complement existing therapies based on the medical model and thereby offer the consumer more options, more *choices* for their lives. Our aim is to exclude nobody. We want to offer our consumers the widest range of choices, the most numerous selection of options for self-empowerment. OLOCII is not about *exclusion but inclusion*. It is definitely not about bigotry and the promotion of stigma, but about putting an end to such things, to crushing such banes to the human spirit. Above all OLOCII is about breaking down whatever barriers stand between we who are mentally ill and whatever it may be that stands between our mental health by giving consumers a powerful voice and meaningful choices. It is about establishing, in the partnership of others if necessary, just what factor or factors Keep Us Well. And for those who have found some of those answers, the conference is about sharing their awareness with those who may not have travelled far enough yet on the road to Wellness.

What do we want to achieve?
We hope that one outcome will be that a new and greater confidence be heard within the voices of mental health consumers in Australia, at the very least amongst those who manage to attend it. We also hope to achieve greater self-determination and a greater range of choices for consumers; we want to demonstrate that we have a voice, that this voice will grow louder rather than softer, and about all that us 'loonies' are here to stay and *will* have our rights and human dignity respected. We have a lot to contribute to society, and to ignore this, to pigeonhole us as 'nuts' or 'crazies' is a criminal waste of talent and expertise.
Enquiries Darren Cocks (08) 8373 2063

Funded under the National Mental Health Strategy by the Commonwealth Department of Health and Family Services

Mental Health Conference

'Our Lives Our Choices II'

Consumer run mental health conference to be held in Adelaide on

17 & 18 October 1998
Australian Mineral Foundation
63 Conyngham St, Glenside, SA 5065

REGISTER NOW
Visit our Website: www.oloc.adelaide.edu.au
Inquiries:
Our Lives Our Choices
Ph. 08 8373 2063
Fax 08 8373 2090

AusEinet's website: http://auseinet.flinders.edu.au

Have you visited out website recently? Given that we have completed the AusEinet workshops, we now have some more time to devote to other aspects of the AusEinet project – such as our website! You may like to try our problem based learning module on depression, or to explore our suggested links – or our conference list which is regularly updated. Have you tried the EINET email mailing list? Send an email to majordomo@auseinet.flinders.edu.au - leave the title/ subject blank and as the text of the message put subscribe einet. In the next couple of months, we plan to add additional "Hot Topics", suicide prevention projects, a copy of the first report of the National Stocktake of Early Intervention programs and a second problem based learning module. We would welcome your comments and contributions at auseinet@flinders. edu.au - phone: 08 8357 5788; fax: 08 8357 5484.

Publications of Interest

National Mental Health Strategy Evaluation Steering Committee, for the Australian Health Ministers Advisory Council *Evaluation of the National Mental Health Strategy: Final Report*, Mental Health Branch, Commonwealth Department of Health and Family Services, December 1997.

This report summarises the evaluation of the National Mental Health Strategy. It succinctly describes the approach to the evaluation and details progress in terms of the evaluation focus areas: promotion and prevention; linkages between mental health services and other sectors; service mix; and the rights of consumers and carers. The report has been prepared in a simple form, 'to synthesise the key messages' emerging from the evaluation team's investigations.

Australian Health Ministers *Second National Mental Health Plan*, Mental Health Branch, Commonwealth Department of Health and Family Services, July 1998.

The Second National Mental Health Plan is intended to 'provide a clear national framework for future activity in mental health reform'. As such, it builds upon the National Mental Health Strategy with the objectives of: promoting the mental health of the Australian community; where possible, preventing the development of mental disorder; reducing the impact of mental disorder of individuals, families and the community; and assuring the rights of people with mental disorder. The Plan aims to consolidate existing reform activity as well as expanding into additional areas of reform. Key themes are: promotion/prevention; the development of partnerships in service reform; and the quality and effectiveness of service delivery.

Copies may be obtained from: Mental Health Branch, Commonwealth Dept of Health and Family Services, GPO Box 9848, CANBERRA ACT 2601. Fax: (02) 6289 8788: website: http://www.health.gov.au/hsdd/mentalhe

Broken Hill Human Services Conference

3rd National Conference for Regional Australia
20-21 November, 1998
Entertainment Centre, Broken Hill, NSW

Purpose: To provide an opportunity for human service workers to "cross-fertilise" ideas and share experiences of their service delivery in the rural and remote communities of Australia.

Theme: Healthy Communities for the Bush.

Inquiries: Barry Fowler, 08 8080 2222, fax 08 8088 1702, or email council@brokenhill.nsw.gov.au. PO Box 448 Broken Hill NSW 2880

Broken Hill City Council Initiative
Supporting Regional Australia
Conference Partners:
Centre for Rural & Remote Area Studies
University of SA Whyalla Campus
Robinson Education Centre, Broken Hill
Web Page http://members.zoom.com.brokenhill

THE NEXT ISSUE WILL BE PRODUCED IN DECEMBER.
DEADLINE FOR MATERIAL WILL BE **FRIDAY 4TH DECEMBER 1998.** PH. 08 8357 5788 OR FAX 08 8357 5484, EMAIL: AUSEINET@FLINDERS.EDU.AU.
PLEASE LET US KNOW WHAT YOU ARE DOING. CONTACT AUSEINET WITH SUGGESTIONS FOR TOPICS TO BE COVERED.
AUSEINET WEBSITE ADDRESS http://auseinet.flinders.edu.au

ISSN 1329-8720
Issue 6, September 1998 - No 4/98

AusEinetter

Guest Editorial

Professor Robert Kosky

What is Normal and What is Abnormal?

One can't work in the field of early intervention or deal with general theories about early intervention in mental health without at some time coming face-to-face with the question of what is normal in human conduct and emotions and what is abnormal?

In most of mental health work this question can be pushed into the background because it is dealing with clear cut, long established patterns of illness, disorder or behaviour, which almost everyone agrees constitutes abnormality. This is not to say that the issues of normality versus abnormality have not been raised in the general psychiatric literature. On the contrary. One of the most provocative and distinguished psychiatrist of this century, Ronald Laing, argued, for some convincingly, that in a mad world perhaps a personal mad experience constituted some semblance of normality. More interestingly, he argued that certain forms of behaviour, which are often regarded as mad, are stratagems to maintain some grip on existence or are the result of being pushed by others to maintain their sanity, or are just products of manoeuvres to deal with irresolvable situations, but which lead nowhere. Thomas Szasz famously argued that mental illness, in particular schizophrenia, did not exist but was a construct in a social and cultural context of a repressive modern society. While Laing's existentialist-based views lead back to a developmental model and the context of the child growing up in the family, Szasz's views have probably been overtaken by cross-cultural data which shows that an illness comparable to schizophrenia seems to exist in human societies that have been cut off from modern industrial developments, although the interpretation of this condition by those societies is often culture bound. Professor Barrett's work on the Iban people of Borneo is of great interest in this respect.

The mental health conditions which are recognised as major disorders are therefore probably real enough. It is not the purpose of this introduction to AusEinetter to undertake a philosophical discourse concerning the nature of reality in mental disorders. Instead I want to try to derive some practical model for the interpretation of the often conflicting results about the prevalence of mental illness, disorders and problems in our community.

The first issue to address is the question of symptoms. What are they and how are they recognised and what relationship do they bear to mental health disorders? It is the understanding of symptoms that is the basis for early intervention. It is the task of early intervention to find symptoms at their earliest onset and manifestation. And intervention can then be made at that point. But what are symptoms? According to one authority, German E. Berrois, symptoms are composed of a neurobiological signal which is interpreted through personal and social codes. The neurobiological signal is the consequence of a neurobiological dysfunction. For this authority the symptom has a basis in a neurobiological dysfunction. It is hard to see any situation in which this description is likely to be incorrect, except if one holds rigidly to a mind/body dichotomy, as would be the case for instance, for certain psychoanalysts and then only because of their focus on what is happening in the conscious and unconscious mind.

So 'symptom' then itself is a complex thing. Roughly, the manifestations of symptoms may occur in two different ways. Most obviously, symptoms may occur as a rupture in ordinary development. The most obvious case of this, for instance in literature, is the madness of Ophelia in Shakespeare's play *Hamlet, Prince of Denmark*. In these cases a person who is previously well becomes unwell over a short space of time. The second pattern of onset of symptoms is where they manifest slowly over time. Gradually someone who was once well becomes unwell, although it is not easy to identify the point at which this changed occurred. In this case the symptoms may really represent a transition from one state to another. An example of this might be the onset of a crippling agoraphobia in later life which began much earlier as shyness. There are of course many variations on these two themes. On the whole it is generally regarded that the sudden,

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more explosive, types of symptom manifestation are more a consequence of some biological problem, while the slower transitional forms are more under the control of the environment. However this is to simplify matters much too much.

One of the issues to be addressed in any consideration of symptoms is how are they derived? One way, the time honoured tradition, is that a group of clinicians who have much experience, and who have studied human development, decide upon and agree to consider emotions and behaviours as being characteristically symptomatic. This is the way the two great modern taxonomies were derived, namely the Diagnostic Statistical Manual and the International Classification of Diseases. It is often thought that these are theory free and culture neutral but from the composition of the members of the committees who make up the industries that these classifications have become, this is clearly not likely to be the case. This fact though does not necessarily invalidate the categories so defined in these taxonomies.

Another way of deriving symptoms is from the bottom up. Populations are searchingly surveyed, usually by questionnaire methods and the responses are analysed statistically. Clusters of responses are sought out and discontinuities are identified. Discontinuous clusters correspond to categories of disorder. Cut-off points are determined by statistical means and above these cut-off points people are defined as having problems or disorders. These methods usually produce a much wider net than the 'top-down' method of people who are identified as having mental health problems.

One tricky issue is the question of prodromal symptoms. Are there symptoms and signs which together do not necessarily make a mental disorder but indicate the incipient onset of mental disorder? If so, these would be a point for intervention in order to prevent the development of the mental disorder. The search for prodromal symptoms has proved frustrating. In general the sorts of problems or disturbances people show before the onset of major categories of mental illness are very non specific and are shared by many people who never develop the disorders. Thus the issue gets down to one of probability measurements of whether or not a particular group of prodromal symptoms indicates the development of a disorder. Should the probability be low then it is likely that interventions would be made with a lot of people where it is quite unnecessary and may be harmful. If the probability is high then there may be a case for early intervention in individuals who show this non specific symptomatology. However, if the probability is high it may be that the prodromal symptoms are in fact the symptoms of the disorder. Professor McGorry and his colleagues have been exercising their thoughts about this particular issue in relation to the early onset of schizophrenic illnesses and there has been recent discussion around this topic in the Australian and New Zealand Journal of Psychiatry.

I mentioned earlier Ronald Laing's view that mental disorders were in fact stratagems of development. This view echoes a long line of British psychoanalytic thought and is particularly illustrated by D.W. Winicott. The model that has been used here is not one of the development of categorical mental illnesses but rather of lines of development. The human organism is seen as interacting with the environment from the word go. These interactions result in adaptations and the adaptations can be beneficial, non-productive or harmful. Some adaptations may be beneficial at first and harmful later and so on.

The developing human organism is thus involved in a series of stratagems to ensure its survival and maximise its potential. Because of the long psychological gestation period of the human infant, much longer than its closest evolutionary companions, the primates, the early interactions between the parenting figures and the developing child are of extreme importance in setting broad schemata for later development. However, it should always be remembered that the human organism is very plastic, very resilient and capable of major corrections in developmental direction. Nevertheless it contains vulnerabilities not only in its biological templates, genetic programming and the mechanisms of transition from genotype to phenotype, but there are also likely to be vulnerabilities in the environment which is by and large created by other humans with all their weaknesses and strengths. This type of view of mental health moves early intervention considerations towards the field in which the human organism develops, mostly the family, and the context in which this occurs, namely the community, which is firstly to deliver the basic necessities of shelter, food and security and then to deliver those uniquely human elements which Karl Popper called World 3 factors, namely the supragenetic transmission of knowledge and regulations. Thus early intervention models derived from this developmental view of mental health will be concerned with these issues.

It can be very easy therefore, to become quite confused about where early intervention should go, and indeed what is the meaning of mental health and mental health dysfunction. I think one easy way out of this, a pragmatic way, is to accept that these two ways of looking at mental health are describing somewhat different groups of people but nevertheless people who are in trouble and do need help.

One way of looking at these issues is to recognise that most surveys of the mental health of populations indicate that about 20 percent of people, that is one in five, have some form of mental health problem which, while curtailing aspects of function, are minimal or moderate in severity. In general, I think it is reasonable to regard these problems as "turn around difficulties". By that I mean that these problems represent poor adaptations to some aspects of field or context, that is a family or community. This is not to minimise them but to indicate that they are problems which represent in the old psychoanalytic terminology, compromises. These are

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stratagems which are being used to keep some form of disturbance in the field or context in some form of perspective for the individual concerned so that they can maintain their survival. In some ways the manifestations of these mental health problems are as variable as the individuals who have them, but in another way they perhaps fit into the two great classes of mental health problems derived from statistical surveys. These are the internalising problems where individuals themselves suffer to some extent and the externalising problems where individuals cause suffering around themselves.

These "turn around difficulties" seem to indicate a contextual developmental approach. One way of approaching them on a community scale would be through risk management. This approach would require an understanding of the relative risks of certain types of situations for the developing organism and the potential mental health outcomes. We have some of this knowledge but it is far from complete and it seems to me that what knowledge we have has been haphazardly acquired and lacks overall synthesis. It may be one of the tasks of early interventionists to bring some order to the knowledge about human development which resides across so many disciplines and in such an uncoordinated fashion at the moment. The second approach to "turn around difficulties" is by the enhancement of individual resilience and of the capacity of the fields and context to provide a facilitating maturation for the child. This was the focus of the work of D.W. Winicott and many other human developmentalists but again the knowledge in this area is reposed in various disciplines and it seems to me that there is a lack of a general theory of human development which takes into account the knowledge that is currently scattered around. This again represents a major task for early interventionists.

While the "turn around difficulties" are manifested in a considerable proportion of the population (and if a longitudinal time approach is taken perhaps they are manifested in many more than are measured on a simple cross-sectional survey), the other type of mental health problem is much less frequent. I refer here to what are severe problems which seem to affect about 2% of the population, that is 1 in 50. These severe problems are perhaps best described as "vicious circle - no way out problems". They represent those stratagems described by Laing which are non-productive and ultimately harmful. They also include the biological problems for which we currently are only on the threshold of understanding and of providing specific treatments. In this case early intervention approaches are probably best directed towards the individual. This is a classic form of early intervention and requires the identification of the symptoms of the conditions and their early treatment. If certain mental conditions can be tied in with prodromal symptoms which indicate a high probability of developing the disorder then these too can be the target of individualised early intervention. It opens the possibility for some mechanisms of screening populations with some hope of spotting those who are going to become seriously ill, without falsely identifying other individuals who would not go on to develop any particular problems. At the moment we are not in this stage for any illnesses except the most clearly biologically based disturbances which are associated with some forms of mental retardation and possibly some forms of depressive illness.

An important issue occurs to me about this type of approach. Our current psychopharmaceutic focus has been on symptoms as targets. Thus we have developed antipsychotic drugs aimed at the symptoms of schizophrenia. However, recent research has indicated that there are background disturbances which may be important to deal with. For instance the current behaviours which are aggressive are probably fairly symptom orientated. However, it may be that the general predisposition to aggressivity exhibited by certain individuals is a more appropriate target. This predisposition may be set by early deprivation experiences which result in lasting neurotransmitter imbalances, which in turn set cognitions and perceptions, which lead to aggressive behaviours, which in turn cut off the reception of affection, and so a vicious circle is developed. Craig Ferris in the United States has shown that this pattern can be experimentally induced in animal models and it is tempting to at least apply the model theoretically to humans. It would suggest that, for instance, cognitive behaviour therapy for aggression determined in this way is unlikely to succeed without a complimentary medication to correct neurotransmitter imbalances and that target orientated medication is likewise unlikely to have lasting effect. Thus, for the "vicious circle - no way out problems" the neurobiology of their development seems to be a particularly important area for future research and the development of our knowledge. Of course this is not to say that the field or context aspects of these very serious mental disorders can be ignored; on the contrary, social breakdown, family breakdown and mental health service system breakdown are often associated as these problems roll on.

In conclusion, one easy way out of the normality versus abnormality dilemma for early interventionists is to reframe the issue in the light of surveys of mental health of populations. These surveys indicate that about 1 in 5 people at any one time suffer from some form of mental health problem while about 1 in 50 suffer from a serious problem. The more common problems are probably best thought of as "turn around difficulties" dependent upon contextual interactions with the individual, while the less common disorders can be thought of as "vicious circle - no way out problems" in which individuals and systems are stuck and where a serious maladaption has occurred. The "turn around difficulties" are probably best dealt with by a contextual developmental approach to early intervention, while the "vicious circle no - way out problems" are probably best approached in an early intervention way with the individual as the target.

I have tried to make a pragmatic distinction between the types of mental health problems that are much quoted following

surveys of the population. I don't think it's helpful to talk about 1 in 5 people suffering from mental health problems without the qualification that most of these are probably fairly amenable to time and intervention, while a much smaller number constitute what is traditionally thought of as people who might be suffering from mental illness. I think it is no help either for early interventionists to confuse these and become embroiled in debate about what is normal and what is not. I hope that the distinction between these problems that I have drawn above will be a helpful way of dealing with this issue. I might say that the terms that I have used for these two types of difficulties are not original. I first heard them at a conference in the United States, in discussion, and I am unable to recall the originator of the terms. As soon as I find out I will let you know.

THE AUSEINET WORKSHOPS

In this issue, we would like to present a brief summary of the AusEinet workshops conducted throughout Australia during the past 10 months. The workshops have been one of the strategies utilised to meet the aims of Stream I of the AusEinet project, the development of the Australian early intervention network for mental health in children and young people. Essentially, the functions of the 'Network' are to:

- draw together and provide increased communication between those whose work and interests focus on early intervention in the mental health of young people, whether they are from Commonwealth or State organisations, government or non-government organisations, professionals or consumers and carers
- develop collaborative links with one key early intervention group or agency in each State and Territory to act as the local co-ordinator for early intervention (the 'spoke' to the 'hub' of the Lead Agency Consortium)
- develop a national clearinghouse for information about the mental health of young people and their families
- improve nationally the general knowledge and basic skills of mental health workers with regard to early intervention with children and young people, through training programs, newsletters, conferences, resource kits and Internet based information
- promote nationally, early identification of psychological disturbance and mental health disorders in children and young people
- promote timely, effective, efficient and appropriate therapy and management for those disorders discovered as part of an early identification program
- publicise nationally results of outcome studies of best practice in early intervention with psychological disturbance and mental health disorders in children and young people

Since its launch in October 1997, AusEinet has staged 11 workshops: in Canberra (October 1997), Melbourne (February 1998), Hobart (February 1998), Brisbane (March 1998), Cairns (March 1998), Kalgoorlie (April 1998), Perth (April 1998), Darwin (May 1998), Adelaide (June 1998), Newcastle (July 1998) and Sydney (July 1998). In all, 1,014 people have participated in these workshops and we have been impressed with the enthusiasm and interest displayed by participants.

Aims of Workshops

In attempting to facilitate the development of the network, the AusEinet workshops have had a number of aims:

- facilitating networking among people directly involved with or interested in the mental health of young people
- showcasing local early intervention projects/programs/activities
- expanding the AusEinet network
- conveying information about the AusEinet project
- collecting valuable information from participants about needs, opportunities and theoretical approaches to early intervention
- developing a cumulative impression of rates of progress towards early intervention in different Australian states and territories
- providing information on the range of early intervention services available, gaps in services and opportunities, constraints and barriers to reorientation of services to an early intervention focus

Evaluation of Workshops

Overall, evaluations of our workshops have been very positive. While it has often been difficult to accommodate all participants who wanted to participate in AusEinet workshops, the AusEinet project team have made a concerted effort to provide their workshops to as many people as possible and in as many locations as possible. Consequently, in addition to conducting workshops in each of the capital cities, workshops were also conducted in Kalgoorlie, Cairns and Newcastle.

At times we haven't been able to cover the range of topics that participants wished for – given that the field of early intervention in mental disorders covers such a large area, it is clearly impractical to try to cover the whole area at any one workshop. Rather, we hope that the dissemination of material on early intervention throughout the life of the AusEinet project and the utilisation of other project stratetgies will assist in meeting the demand for information on early intervention in particular areas.

A further critique of the workshops relates to participants' desire for more practical information on early intervention strategies. AusEinet aims to address this needs through its series of AusEikits and AusEitraining resources

There have been infrequent complaints about venues used, catering, lack of parking facilities – even the quality of free pens provided to participants! While we are appreciative of any feedback received and endeavour to act upon it, we feel it is important to point out that workshops were provided free

to participants and we wanted to accommodate as many participants as possible. It was necessary to achieve this within the confines of our budget. We are very appreciative of the many positive comments that we have received.

Workshop content

In addition to presentations from members of the AusEinet project team, workshop speakers and topics have included:

- Professor Mark Dadds: "Early intervention with emotional problems in children and adolescents" (Canberra)
- Ms Bernadette Dagg: "Early intervention in psychosis" (Canberra)
- Mr Peter Humphries: "Early intervention: a practitioner's perspective" (Canberra)
- Ms Kerry Borewitz and Shan: "The young ones" (Canberra)
- Mrs Angela Josephs and Mrs Chris Handley: "Children of Parents with Mental Illness: the Tasmanian Children's Project" (Tasmania)
- Ms Kate Shipway: "Mental Health Issues in our Schools" (Tasmania)
- Professor Bruce Tonge: "Young people with intellectual disability" (Melbourne)
- Professor Barry Nurcombe, Royal Brisbane Hospital: "Interventions in Child Sexual Abuse" (Brisbane)**
- Karen Turner: "The Positive Parenting Program: Triple P" (Brisbane)**
- Mr Richard Webb, Mater Hospital: "The Parent Aide Program" (Brisbane)
- Ms Maria Donald, Griffith University: "The evaluation of the Youth At Risk Program" (Brisbane)
- Professor Ernest Hunter: "Early Intervention: Is it Possible in Indigenous Communities?" (Cairns)**
- Mr Rob Hanlon: "Being Responsible" Helping Kids Make it" (Cairns)
- Mr Nigel Inskip: "Peer Support Group" (Cairns)
- Mr Neil Macleod: "The Palm Island Mental Health Program" (Cairns)
- Dr Christine Jeffries-Stokes: "A paediatrician's perspective on early intervention" (Kalgoorlie)**
- Ms Jenny McCulloch: "An overview of early intervention strategies" (Kalgoorlie)
- Ms Elsie Edwards: "The NTP Project: ngunytji tjitji pirni" (Kalgoorlie)**
- Mr John Titmus: "Early Intervention in Psychosis" (Kalgoorlie)**
- Professor George Lipton: "Early Intervention in Mental Health Disorders" (Perth)
- Professor Robert McKelvey: "Determining the Mental Health Needs of Vietnamese Children" (Perth)**
- Ms Anwen Williams: "Early Intervention in Behavioural Disorders: the Triple P Program" (Perth)**
- Dr Clare Roberts: "The Aussie Optimism Project" (Perth)
- Ms Annette Stewart: "Mental Health Issues in Schools" (Perth)
- Professor David Hay: "The Needs of Children with a Mentally Ill Parent" (Perth)
- Professor Patrick McGorry: "Implementing best practice guidelines for early intervention in psychosis" (Adelaide June 1998)
- Professor Ken Rigby: "Effects on the mental health of adolescents of perceived parenting and peer victimisation at school" (Adelaide June 1998)**
- Mr Ian Pearce: "Early intervention in behavioural disorders: the behavioural intervention program"
- Ms Wendy Jenkins: "The Hospital to Home Transition Team: a Brief Overview"
- Dr Anne Sved-Williams: "Post natal depression and infant mental health" (Adelaide)**
- Professor Graham Vimpani: "Building neighbourhood networks: a fundamental building block of early intervention" (Newcastle)**
- Professor Philip Hazell: "Early intervention in bi-polar disorder in children" (Newcastle)
- Mr Paul Drielsma: "At risk of what? Justifying the expense of early intervention family support" (Newcastle)**
- Ms Catherine O'Brien "Introduction of a mental health liaison service into a children's hospital" (Newcastle)
- Ms Cathy Mackson "Young people and psychiatric illness intervention and assessment project" (Newcastle)
- Professor Beverley Raphael "Getting in early: new initiatives" (Sydney: July 1998)**
- Mr John Cooper: "Early intervention in preschools: where do we go from here?" (Sydney)**
- Mr Stephen Matthey: "Perinatal intervention – theory and practice; research and reality" (Sydney)**
- Tim Keogh and Ann Calleen: "Perinatal intervention – theory and practice; research and reality" (Sydney)
- Dr Nick Kowalenko "Fear busting and mastering the miseries: tackling internalising problems through early intervention" (Sydney)**

** indicates that summaries of these presentations have either been received or are currently being developed by AusEinet project staff and will appear on the AusEinet website.

Key findings of small group discussions

What Would You Like To Get Out Of The AusEinet Project?

(1) *Information networks*

Many participants in the AusEinet workshops saw the dissemination of information to support early intervention activities as one of the main roles of the AusEinet project. Specifically, participants wanted AusEinet to provide information on:

- early warning signs
- the validity of models of early intervention and optimum times for intervention (windows of opportunity)
- evidence of efficacy of early intervention programs
- identification of best practice (How? When? Where?) and information on support structures for these practices
- identification of current research activities
- a comprehensive listing of resources
- funding sources

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- information on cost effectiveness of early intervention strategies

A frequent observation of workshop participants was that little was known about other early intervention activities occurring in their local area as well as in other states and territories. Additionally, participants frequently expressed concern that little information was disseminated about the results of national projects or research activities. The development of a national clearinghouse that provided access to current literature on child and adolescent mental health issues was seen as a key role of AusEinet. A variety of means of dissemination of information were identified including fact sheets, workshops, seminars and conferences.

AusEinet is able to provide information many of these areas. The AusEikits being developed through the life of the project as well as the clearinghouse, will provide information on early warning signs, models of early intervention and optimum times for intervention, efficacy of early intervention strategies, current research activities and cost effectiveness. Where possible, the project staff provide information (via the clearinghouse) on possible funding opportunities and resources.

(2) *Assistance*

A number of workshop participants saw AusEinet as providing assistance to them. This assistance went beyond that of disseminating information and included:

- access to professional support when developing, implementing and evaluating new programs. That is, access to specialist researchers, guidance with research methodology and an up-to-date listing of the most valid and reliable instruments for measuring the many dimensions
- assistance in developing program outcome measures
- assistance with developing submissions and in undertaking research projects
- assistance with accessing the funding dollar

While AusEinet project staff are keen to assist members of the network in accessing information to assist them, it is not possible to provide 'hands on' assistance in these areas within current funding.

(3) *Networking*

AusEinet's role in facilitating networking was another common theme in discussions of workshop participants. It was suggested that AusEinet could assist in forging links between different sectors working in early intervention and could broaden, strengthen and reinforce any existing networking. Additionally, it was considered that AusEinet should have a key role in changing the community's perception of mental health/illness.

The AusEinet project staff believe that the workshops, production and dissemination of the AusEinetter, the establishment of the Website and EINET (chat line) have all facilitated the development of networking. AusEinet clearly is the 'hub' of the network – much more work needs to be undertaken to develop the 'spokes' (i.e., clearly established and identifiable parts of the network throughout Australia).

(4) *Advocacy*

Advocacy was also a key theme from the AusEinet workshops' small group discussions. It was believed by some participants that AusEinet could lobby governments for funding for research and resources and influence policy and practice to prioritise early intervention

What else would you like to see?

A range of responses were offered by workshop participants. The need to provide more focus on indigenous issues and on people from a non-English speaking background was frequently identified as was the need for more consumer involvement. It was also suggested that AusEinet needed to collaborate with young people. Other suggestions included the provision of reference lists; a Website focusing on early intervention in schools; consultation/supervision; seminars, workshops and conferences; training and training resources; a chat site providing the opportunity to express ideas in a wider context and having people respond to it via email.

What other conditions/disorders/issues would you like the project to address?

Participants identified a broad range of conditions/ disorders/issues to be addressed by the project. In addition to the major mental disorders (e.g. depression, anxiety, bipolar disorder and schizophrenia), other key areas included: cultural issues that affect diagnoses; vulnerability and risk factors (and screening) and relationship of these to developmental stages; resilience and protective factors; attachment problems; loss/grief; children of parents with a substance abuse problem/mental illness; shyness, social isolation, loneliness; school problems and learning difficulties; comorbidity; self-injurious behaviour; working with challenging clients; family violence.

It was further suggested that early intervention programs needed to be explored across different contexts and in different sites (recognising the impact of service provision and that the material developed needs to be as jargon free as possible and should incorporate the latest relevant research). That is while recognising the importance of utilising evidence based research, this needs to be considered in terms of different contextual influences.

What Early Intervention Services are Currently Operating?

Generally, workshop participants were able to provide information on a broad range of local early intervention services. Where possible, information on these services will be obtained and included in the second Report of the National Stocktake of Early Intervention Programs

What Gaps Exist in Early Intervention Services?

Invariably, numerous gaps in services were identified. While some of these were specific to the particular locations

workshops were held in, others could be generalised. These included: lack of individual counselling services for children aged 4-14 years; integrated education programs in the school curriculum; early intervention of mental disorders in the juvenile justice system; lack of alternative housing for young people; long waiting lists; services for children of parents with a mental illness; programs for infants (e.g. for those with a mother with post natal depression); social skills training and support for children with dual diagnoses; long-term placements for students with mental health problems; more parenting education; behavioural intervention services; and more work orientated programs for young people with mental health problems.

Opportunities

Opportunities identified for reorientation of services to early intervention included the AusEinet project itself and the New Mental Health Plan. The AusEinet project was seen as the beginnings of a national network – a new movement which could help facilitate momentum for change to more of an early intervention focus. The existence of an organised consumer network was also seen as an opportunity.

What is preventing this from happening?

Participants at the AusEinet workshops invariably identified a range of barriers and constraints. Lack of resources was most frequently identified as a major barrier. In particular, it was noted that funding arrangements for programs were frequently of short duration. This made it difficult for organisations to evaluate the effectiveness of specific programs. Further, because many organisations were reliant on a range of funding sources, applications for funding often become the priority, rather than service changes. Other barriers/constraints included: lack of awareness and knowledge; time constraints; lack of training opportunities; political agendas; geographic constraints; lack of skilled workers; organisational attitudes and lack of linkages between services. Competition between services (especially given the climate of competitive tendering) and 'ownership' of clients and client groups were seen as further constraints. More basic barriers identified included difficulties defining early intervention; lack of 'top-down' support for early intervention and early detection/case finding; and ethical and clinical issues around screening.

Where To From Here?

Opportunities for future networking

Recent national early intervention in mental health projects have employed a variety of models. The National Early Psychosis Project (NEPP) was auspiced and managed by the Early Psychosis Prevention and Intervention Centre (EPPIC), University of Melbourne and was implemented through the appointment of Project Co-ordinators for each State and Territory. Co-ordinators were employed by their respective State and Territory health departments but were also accountable to the National Office via the National project manager. Co-ordinators were asked to provide quarterly reports to the National Project Manager and each State and Territory mental health division also designated a person to act as Liaison Officer for the Project. National Co-ordinators' meetings were held at regular intervals during the Project and another mode of communication was through the National Early Psychosis Resource Centre which was managed from the National Office. The Evaluation of the National Early Psychosis Project identified both strengths and weaknesses of the project Model (cf Joyce and Hurworth 1998). Strengths included the access to information, resources and colleagues; the project's status as a national initiative, together with the aim of getting a consistent national approach in the field, and the shared funding arrangement between the Commonwealth and the States and Territories which was seen as resulting in greater investment in the NEPP by the States and Territories, and a greater commitment to its aims (Joyce and Hurworth 1998:48). Problems associated with the model included lack of clarity and definition regarding the role of State Liaison Officers, budgetary constraints and dual accountabilities for State/Territory Co-ordinators.

The Griffith Early Intervention Project (GEIP), similar to NEPP, focused on information dissemination and promotion in its early stages and this generated interest in the training provided. It operates using a 'bottom-up' approach, working directly with service providers. Given that it involves a discrete treatment 'package', it makes it easier to work directly with programs and provide specific resources for their implementation. Joyce and Hurworth (1998:50) comment that while this approach has been successful in getting many programs up and running in the field, the change is unevenly distributed across the States and Territories, and across regions within them. It should be noted, however, that GEIP is currently attempting to build on its initial activities and awareness in the field and to achieve more systemic change.

AusEinet is significantly different in terms of its scale and its focus. It has a much larger budget, is of longer duration, and comprises three streams of activities. In contrast with both NEPP and GEIP, it does not have the same level of contact and access on the 'ground' in each state and territory. As a consequence, it faces particular challenges in facilitating widespread change in the mental health field. In terms of the development of the network, AusEinet's approach has been based on the 'hub' and 'spoke' model. While at this stage the 'hub' of AusEinet is clearly established, much work needs to be undertaken to develop the 'spokes'. How might this be achieved?

Initially it was hoped that the AusEinet workshops would generate interest among local workers and encourage the development of linkages and networks. It is difficult to assess to what degree this has occurred. An oft repeated request has been for AusEinet to provide participants at workshops with an attendance list to facilitate such networking. Unfortunately, however, on those occasions when we have asked workshops participants if they would be agreeable to having their mailing details disseminated, several participants have refused permission. Consequently, we have not been able to act on this request.

HLA

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The establishment of EINET, the early intervention chat line is seen as another means of enhancing networking. As this is only in its early stages, it is difficult to assess its impact. Other strategies utilised thus far include the dissemination of AusEinetter, the development of the first Report of the National Stocktake of Early Intervention Programs, and the establishment of the AusEinet clearinghouse. The placement of mental health workers in a variety of organisations through the reorientation stream of the AusEinet project will also influence the networking process.

What do you think we can do to facilitate networking? How can we develop the 'spokes' of the AusEinet 'hub'? Should we endeavour to develop state/regional based interest groups? Who should take the lead for this? Should interest groups be developed around different contexts, for example, schools based early intervention programs? How can the AusEinet network be sustained? As we are keen to develop a strategic plan for the further development (and sustainability) of the network, we would really appreciate your comments and suggestions.

Please forward any comments or suggestions to Cathy Davis, Senior Project Officer, AusEinet. Email: cathy.davis@flinders.edu.au Phone: (08) 8357 5788; fax: (08) 8357 5484.

Reference:

Joyce, C. & Hurworth, R. (1998) *Evaluation of the Early Psychosis Project.* Centre for Program Evaluation. The University of Melbourne.

The National Stocktake of Early Intervention programs

Hopefully you have received a copy of the first Report of the National Stocktake of Early Intervention Programs. We are currently collecting information for the second report, which we hope to print and disseminate in early-mid 1999. Please give us some feedback on the first report (you will note that an evaluation form appears in each copy of the report) and advise us of any other early intervention programs you are aware of.

For a copy of the stocktake questionnaire, please contact: Cathy Davis, Senior Project Officer, AusEinet. Email: http://auseinet.flinders.edu.au phone: 08 8357 5788; fax: 08 8357 5484

EINET

Have you subscribed to the AusEinet early intervention email mailing list. To subscribe, please email majordomo@auseinet.flinders.edu.au In the text, write subscribe einet in the mail message body.

The AusEinet Conference...

An Inaugural National Conference on Early Intervention in Mental Health, tentatively titled

"Risk, Resilience and Results"

will be held on June 6th - 8th, 1999 at the Adelaide Convention Centre.

We anticipate that a number of international speakers will participate (Dante Cicchetti, Dr Patricia Mrazek and Dr David Mrazek have been invited). We also hope that many members of our network will be able to participate in our conference. The purposes of this conference are to display many of the deliverables of the AusEinet project (including AusEikits and AusEitraining resources), to showcase early intervention programs, to explore issues of sustainability of the network, to discuss reorientation issues, to investigate opportunities for ongoing networking, to provide further information on early intervention practice models and strategies and to generate further momentum for change.

Further information on the conference will appear in the next issue of AusEinetter. Please register your interest with the Secretariat, SAPMEA Conventions, 68 Greenhills Road, Wayville SA 5034. http://www.sapmea.asn.au\auseinet.htm

AusEinet Database

The AusEinet database is steadily developing. To assist us please complete the following details and forward to AusEinet if you would like to be informed of future AusEinet activities, nationally or in your own State or Territory.

Name: .....

Organisation: .....

Address: .....

.....P/C.....

Telephone:.....Facsimile:.....

Email: .....

Return to AusEinet C/- CAMHS, Flinders Medical Centre, Bedford Park SA 5042. Telephone: 08 8357 5788 Facsimile: 08 8357 5484 Email: auseinet@flinders.edu.au

THE NEXT ISSUE WILL BE PRODUCED IN DECEMBER. DEADLINE FOR MATERIAL WILL BE **FRIDAY 4TH DECEMBER 1998.** PLEASE LET US KNOW WHAT YOU ARE DOING. CONTACT AUSEINET WITH SUGGESTIONS FOR TOPICS TO BE COVERED.

AUSEINET WEBSITE ADDRESS http://auseinet.flinders.edu.au

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ISSN 1329-8720
Issue 7, December 1998 - No 5/98

Guest Editorial

Promoting Family and Community Resilience in Indigenous Communities: Cultural Adaptation of the Resourceful Adolescent Parent Program

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Over the past few years the Griffith Early Intervention Project has been involved in the national dissemination of the Resourceful Adolescent Program (RAP) for the prevention of depression in young people. A recent grant from the Commonwealth Department of Health and Family Services under the National Youth Suicide Prevention Strategy is supporting an extension of this work to include adaptation of the RAP Parenting Program for Indigenous communities. The Resourceful Adolescent Program for Parents (RAP-P) aims to provide an opportunity for parents to reflect on their personal strengths on the assumption that the self-esteem and confidence of parents are fundamental to effectively promoting self-esteem and confidence in their children. The program helps parents consider the relationship between stress and their own emotional reactivity in interpersonal situations and works towards increasing parental effectiveness by encouraging emotional regulation and emphasising the importance of social support. The program provides a forum to consider ways of avoiding conflict, or more importantly, promoting harmony.

The "Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families" lists reduced parenting skills amongst the effects of removal of indigenous children. Forced removal of children prevented the opportunity for these children to experience a normal family life (often experiencing institutionalised living and physical, sexual and emotional abuse). To some extent indigenous people may have internalised the major premise of the official policies that aboriginal parents could not provide adequately for their children, that is, were not good enough parents. This, combined with other well documented injustices that tore indigenous communities apart, has contributed to the high rates of social problems in indigenous communities. Thus, there is a great need for interventions designed to enhance parenting practices in indigenous communities.

Risk factors for emotional health problems are experienced by the majority in some indigenous communities, for example in remote areas where indigenous people live in "unremitting need and adversity" (Hunter, 1998). This raises the issue whether prevention programs are adequate in addressing the immediate problems of these communities. A fundamental assumption of prevention, that distinguishes such interventions from treatment programs, is that many participants of the interventions are currently functioning adequately. Involvement in the prevention program, so the theory goes, will ensure functioning remains adequate. Professor Hunter is correct in pointing out that "the factors or conditions indicating risk are experienced universally" in many indigenous communities. However, we believe this should not be taken to mean that the high level of risk is at the expense of protective factors. Despite the adversity, indigenous communities have shown tremendous resilience in the face of adversity. The extensive extended family and community systems that have survived through the period of colonisation are testimony to this. The fundamental assumption of the RAP Parent program is that parents enter the program with existing personal resources. There is a need, however, for indigenous parents to recognise and acknowledge their vast collective and personal parenting resources, inherited from family and community across the generations. Based on the principles of caring and sharing, these resources are all-inclusive and non-discriminatory in their practice. An important contribution of the RAP-P program is in focusing parents on their existing strengths. This component of the program has been extremely successful in workshops run in indigenous communities, both in central Queensland and North Western

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New South Wales.

While a program such as RAP-P includes concepts universal to parents, adaptation to a particular cultural group must be carried out with the involvement of the communities for which it is targeted. In order to ensure modifications are appropriate for the indigenous community, a partnership between the indigenous and non-indigenous groups was established with the plan to work through a process we initially divided into three stages. Stage 1 involves community consultation, in which the needs of young people and their parents and attitudes to RAP programs are established. We hope to learn whether the programs will be relevant to these communities, what adaptation, if any, is necessary to the content of the programs, including any new resources that may need to be developed (audio-visual aids), and the best mode of delivery in which to make the programs accessible to these communities. In Stage 2, based on the community consultation, the program is to be adapted and resources appropriate for the preferred mode of delivery (eg, a video) developed. In the final stage of the process, the programs will be trialed and evaluated in different communities.

To date, consultation has involved presenting workshops to community people, including carers (acknowledging the role of extended family and community in child care) and professionals. We used this approach because there needs to be an exchange of information, rather than a one-way process of taking from communities and giving nothing in return. In the past, information has been taken from indigenous communities and has left community people dissatisfied and disappointed. Often members of the indigenous communities do not hear back from those groups who raised community expectations, or else too much time elapsed since the consultation and meanwhile nothing changed within the community. Additionally, in aboriginal communities those programs that have been implemented in communities are often not adequately supported by external agencies to ensure their sustainability. Reasons for failure of programs include the lack of long-term goals, a lack of external support and ongoing funding and programs that are not culturally appropriate and fail to meet the needs of the community. A lack of acknowledgment and reward to community members who train in and implement programs can lead to burn-out in those who take on the responsibility of program implementation. Taking the above into account, we believe it is vital to place program development and implementation back into the community's hands so that the communities can assess the appropriateness of the program and their role in implementation.

In regards to the content of RAP-P, it is essential that aboriginal parents be given the opportunity to reflect on the existing skills, experience and knowledge of parenting within their community. The starting point of the RAP-P program is to encourage these reflections. The experience of workshops to date indicates that this aspect of the program is successful in motivating parents and other members of the community and in enhancing a sense of confidence in parenting abilities.

While RAP-P has shown promise in giving parents confidence, further work is currently being undertaken addressing the content of RAP-P from an indigenous perspective. For Aboriginal people any program must address physical, mental, emotional and spiritual dimensions. This is in keeping with traditional Aboriginal holistic approaches to social and emotional wellbeing of individuals and community.

In addition to adapting the content of a program for indigenous communities, it is important to consider the context in which it is to be implemented. There is value in considering community involvement to be the major goal as opposed to individual parent or family involvement. Initially whilst numbers may be limited, the people who usually come to the program are those who see the value of such initiatives, are concerned about the level of dysfunction in their community and are committed to making changes. Thus program should aim to strengthen communities not just individual parents or families. For example in work being carried out in Woorabinda (in Queensland), the first step is to set up community support structures along lines that have worked in the past and allow for community representatives to lead the way.

A parent program for aboriginal communities must also consider models for targeting high-risk parents who may not normally engage in programs or who require other interventions targeting grief, trauma, domestic violence, substance misuse and so on. Parent programs such as RAP-P need to be seen as just one type of intervention that can benefit communities. Adjunct treatments, for example, targeting grief or the trauma of family and community violence, will, in many cases, be required. Further research is needed to determine whether individuals who have suffered emotional traumas would benefit from programs targeting these traumas prior to, alongside or following programs designed to enhance emotional resilience and parenting ability. This is an important question that has been repeatedly asked. It is hoped that future developments of early intervention programs will be designed to investigate this issue. Skills based programs have their place, but will be enhanced if communities have the opportunity to deal with the impact of family and community violence, and in the case of indigenous people, the impact of intergenerational trauma. If early intervention programs are to be implemented nationally, to meet the diverse needs of our society, it is vital that we address these issues sooner rather than later.

Hunter (1998) points out that early intervention and prevention models presume basic services are in place to support and sustain such initiatives. There is a great need for mainstream health, education and welfare agencies to support such programs. Within indigenous communities, community

people are a vital resource to the process of establishing and implementing programs. They are the people who will best understand the community's needs and have first-hand knowledge of people in most need of the services being offered. The initiative will come from those people who see the benefits of programs and who want to see changes within their community. They will through their own processes of consultation, persuade others of the advantages of a program. Community strategies for dealing with problems is simple and involves family and community participation; it is based on the old ways of maintaining culture and Aboriginal ways of being and has strong family values as its basis. For example, teaching culture and old bush skills to young people and going out in the bush camping with family and others. Also elders and those in parental roles being available for young people to talk to and confide in. Focusing on our young people and re-establishing a family and community lifestyle which nurtures and guides towards a quality life.

Future Directions

The Indigenous Program of the Resourceful Family Project is currently producing a video and training manual. These resources will be used to facilitate implementation of the program in different indigenous communities. The video is based around a two day residential workshop conducted in Rockhampton with a group of Murri people from the Rockhampton and Woorabinda communities. The filming of the workshop provides a record of the major concepts of the RAP-P program from an indigenous perspective. The intention is for this video to provide the basis of workshops in other Indigenous communities. In addition to the video, the RAP-P manual is being rewritten to include culturally relevant material. The manual will provide Indigenous group leaders with a rationale for the program and suggestions for running workshops. It is anticipated that these resources will be available in early 1999.

The extent to which the resources will meet the need and impact on the diverse range of indigenous communities, is an important question to be evaluated. In the longer-term, sustainability of such initiatives in indigenous communities will only be possible with provision of relevant infrastructure in the communities.

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National Inquiry into Separation of Aboriginal and Torres Strait Islander Children from their Families. (1997). Bringing Them Home : Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families. Sydney: Human Rights and Equal Opportunity Commission.

Get Your Early Intervention Here - No delays!!

The AusEinetter, and more recently the AusEinet discussion group, (EINET) have tackled the topical issue of defining early intervention. The easy answer is to intervene at the earliest stage possible, and this usually directs discussion or training towards the identification of early illness signs, in addition to underlying risk factors. It may even raise further discussion on the moral issue of intervening during the prodromal phase of an illness and possibly 'treating' someone who is more than likely a 'false positive'. We are also undertaking more and more research into the predictive factors for mental illness onset, and attempting to better equip all people with knowledge and skills of protective factors to build up their resilience and possibly reduce vulnerability. These prevention and promotion initiatives are certainly in line with early intervention. But are we shifting too far too fast across the intervention spectrum (Mrazek & Haggerty, 1994), and ignoring intervention at the stage of 'case identification', the stage of most effective intervention (for example Loebel, 1992)?

In public mental health services, we continue to see people with a severe mental illness presenting for the first time, yet giving an account of an illness history of many months, and sometimes years, duration. They finally access psychiatric services when the symptoms are so severe or well advanced that they can no longer be ignored, yet the entire world around them is affected. This usually means a greater need for more intensive intervention (even inpatient admission), a longer time to remission and with some illnesses, a less complete recovery. The impact may therefore be greater than need be, on both their family and health services.

The barriers of access to mental health service, for those people with an emerging mental illness, need further attention. It is currently a difficult time to suggest improved service access when most public mental health services are not funded sufficiently to cope with demands. But let's ensure that our energies and any additional funding for early intervention are not solely used for mental health promotion and prevention, but will also assist in the development of strategies to discover those with an illness at the earliest possible time. We will also need to discuss and address the moral issue of more assertively applying effective therapeutic interventions, to 'improve' the lives of clients and carers experiencing a mental illness already. But if we get it right, won't the outcomes speak for themselves?

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Mrazek, P.J. & Haggerty, R.J. (Eds) (1994). *Reducing Risks for Mental Disorders.* National Academy Press: Washington DC.

Christopher Wigg, Former Coordinator, Early Psychosis Project (SA), Southern Mental Health, Adelaide

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Out of the Blues "The Agenda for the Future" Seminar

The National Seminar on Depression in Young People was held at the Radisson Playford Hotel in Adelaide on 6-7 November. 200 delegates attended with a high proportion coming from interstate, perhaps signifying the level of interest in the issue of depression in young people and providing an opportunity to join forces at a national level.

The meeting has been acclaimed as a great success. Feedback to date suggests that the 'timing' was right for such detailed discussion on this topic, and that the program, the venue, and the chance to get together with colleagues, provided for two days of profitable discourse.

The seminar was designed to provide an overview of important issues about the current thinking on recognition and management of depression in young people. We were very proud of the range and quality of the presentations, with topics covering the research and clinical aspects of depression, incorporating results from large population studies and selected for their contribution to adolescent psychiatry. The participants' evaluation of the seminar was most encouraging, and made us aware of the complex diversity of professionals and interest areas represented, which makes the design of the 'perfect' meeting a real challenge.

A strong focus on school based studies highlighted the fact that schools are a natural environment for the identification of young people with symptoms of depression, but at the same time these projects emphasized some of the difficulties attached to working in schools when undertaking this kind of research. Other popular subjects were the programs aimed at working with marginalized young people and skill development projects.

This national meeting solely dedicated to depression in young people must be regarded as a noteworthy event and hopefully has set the scene for the direction of future work in the area and played a role in increasing collaboration between professionals. It would also be nice to think of it as the inaugural meeting in a recurrent series.
Kerin Williams, Project Officer, Out of the Blues, Telephone 08 8204 5412.

Offspring

Offspring is a program for children and adolescents with parent[s] with a diagnosed serious (Axis I) mental illness. Clinical experience, research and consultation with relevant agencies tell us that many children and adolescents within these families experience a range of social, psychological and economic problems.

Currently within this program we have a peer support group for adolescents 12-18 years. This group is facilitated by two CAMHS' therapists in consultation with three youth consultants.

For further information please contact Tony Colhoun on 08 8326 1234 or Carole Meech on 08 8298 7744

The AusEinet Project Team wish you the compliments of the season and a bright and prosperous New Year

AusEinet's Office at CAMHS at Flinders Medical Centre will be closed from Wednesday 23.12.98 to Friday 8.1.99 inclusive.

Changing Families, Challenging Futures
6th Australian Institute of Family Studies Conference, 25-27 November 1998

The Australian Institute of Family Studies (AIFS) held a very successful conference in Melbourne in late November at which AusEinet participated. Keynote speakers included Dr Richard Eckersley, Ms Mary Murnane and Professor David Thomson. Dr Eckersley presented a thought provoking and challenging address entitled "Making Progress: Shaping the future to human needs" which AusEinet hopes to present a summary of on our Web site in the new year (subject to permission).

A series of concurrent sessions addressed a range of topics related to the theme of Changing Families, Challenging Futures. These included a symposium on changing perspectives on Australian fatherhood; a number of presentations related to affects of divorce on children and young people; and sessions dealing with child abuse and protection, families and poverty, youth, evaluation and on youth suicide prevention. A summary will appear on AusEinet's Web site in the new year.

AusEinet

The Australian Early Intervention Network for Mental Health in Young People

CONFERENCE

"Risk, Resilience & Results"

to be held at

Adelaide Convention Centre
6th - 8th June 1999

Expressions of Interest
Contact: SAPMEA
68 Greenhill Road
PARKSIDE SA 5063
Phone 08 8274 6060
Fax 08 8274 6000

Invited Speakers include:

Assoc Prof Stephen Zubrick
Assoc Prof David Fergusson
Mr Sven Silburn
Professor Patrick McGorry
Dr Alan Rosen
Dr Ian Shochet
Professor Jan Carter
Professor Beverley Raphael

Email conv@sapmea.asn.au
For further information visit the Conference website:
http://www.sapmea.asn.au/auseinet.htm

The program committee encourages abstract submissions on early intervention in all its forms as applied to a range of mental health problems, issues and disorders. Papers may be theoretical in nature, or address practice/clinical management, training, research or policy issues.

Funded under the National Mental Health Strategy by the Commonwealth Department of Health and Family Services

Second Report of the National Stocktake of Early Intervention Programs

Completed questionnaires are currently being received for inclusion into the Second Report of the National Stocktake of Early Intervention Programs. To date, we have received information on a further 95 self-identified early intervention programs encompassing a broad range of mental health problems/issues and conditions, target groups and intervention strategies. This material will be compiled from mid January to mid February and it is anticipated that the second report will be printed and disseminated in April 1999. We are still accepting material for inclusion into the report. Please contact Cathy Davis if your require a copy of the stocktake questionnaire.

We are also appreciative of the feedback we received on the first Report.. Lack of space presents us from including a detailed analysis of the stocktake report evaluation in this issue of AusEinetter. (This will be incorporated in Issue 8 of AusEinetter). Overwhelmingly, however, feedback has been positive. We will be incorporating some of the suggestions contained in the feedback in the second report including the addition of a glossary. The indexing will also be improved.
For further information, contact Cathy Davis, Senior Project Officer, AusEinet, 08 8357 5788, fax 08 8357 5484 or email cathy.davis@flinders.edu.au

AusEinet Reorientation Placements: The Who's Who of Stream II

Under Stream II of AusEinet, we have funded the placement of mental health workers in eight agencies across Australia. The mental health workers' task is to implement, and assess the viability of, reorientation to early intervention within their agency. Most of the placements have been under way for four months and have six more to go. The common objectives of the placements are to:

- Identify opportunities for and barriers to reorientation within the agency
- Implement strategies for reorientation
- Assist staff to develop skills in early intervention
- Establish / strengthen links with other agencies
- Evaluate the viability of reorientation

Beyond these, the mental health workers are working hard to achieve their specific objectives. Strategies for sustaining reorientation have been an important underpinning right from the start and will be a major focus for the remainder of the placements.

Until now I've been referring to this group of very talented people as generic 'mental health workers'. It's time to lift the veil of anonymity! Names, phone numbers and achievements are shown below (though this brief summary hardly does justice to their efforts so far). Further updates will be given in subsequent issues of *AusEinetter*. Note also that each of the 'mental health workers' has been invited to report the final outcomes of their placement at AusEinet's 'Risk, Resilience and Results' conference in Adelaide 6-8 June 1999.

Glen Ochre and Ed McKinley have completed their consultancy for the ***Mildura Aboriginal Corporation***. The first three day introductory Spiritual Healing Workshop was held at Mildura in September. The second and third workshops were held at Commonground in Seymour, Victoria in October and November. We've received written reports and evaluation videos from Glen and Ed and from ***Sally Jo Sherger*** of the Mildura Aboriginal Corporation. The initial response to the workshops has been overwhelmingly positive, both from the participants and the consultants. Sally Jo will now assess the ongoing impact of the workshops within the community.
Contact Sally Jo Sherger on (03) 5022 1852

Barrington Support Service in Devonport, Tasmania is a school based service seeking to increase awareness of mental health issues by training specialist staff and teachers in five pilot schools. ***Pam Lehman*** is coordinating personal development sessions on anxiety in the pilot primary schools and depression in the pilot secondary schools. The FRIENDS program has been implemented in the primary schools and the response from teaching staff has been overwhelming. Sustainability will be achieved by networking with other agencies and systems, developing partnerships with specialist support staff and forming a consultative committee of young people in schools.

Contact Pam Lehman on (03) 6424 1966

Anglicare (formerly Careforce) in Rockhampton, Central Queensland is seeking to achieve reorientation across a large geographical area, parts of which have few mental health resources. The main strategies are to raise awareness of mental health issues faced by young people by providing information to a broad range of agency staff. ***Selena Cleveland*** has run information sessions with staff from the eleven targeted Anglicare agencies in Central Queensland, compiled a Training Manual and evaluated the process to date. Sustainability will be achieved by training key personnel and establishing links with other agencies.

Contact Selena Cleveland on (07) 4927 8200

Children of Prisoners' Support Group (COPSG) in Sydney, New South Wales is seeking to help children and young people with mental health problems such as anxiety, depression and disruptive behaviours. ***Erica Pitman-Smith*** has implemented a series of information sessions for COPSG and Department of Community Services staff as well

as staff from a variety of other agencies, each focussing on a particular disorder or issue. Expert guest speakers have been invited to run the sessions. A resource manual and referral list will be finalised in the next phase of the placement. Sustainability of reorientation will be achieved by establishing and/or strengthening links with other agencies via extensive networking.

Contact Erica Pitman Smith on (02) 9648 5866

Southern Public Health & Department of Education in Albany, Western Australia are aiming to realign their agencies' policies and practices in order to deliver early intervention programs to school children and adolescents up to the age of 17 years. Sustainability is at the core of this placement and will be achieved at the policy level. ***Brett Kipling*** has drafted a set of objectives and principles of cooperation for the district interagency policy, is developing a model of interagency collaboration and has established an Interagency Manager's Forum. He has attracted the interest of local general practitioners and the local media and has held preliminary discussions with Education Department of WA staff in Perth about incorporating Early Intervention principles into state policy.

Contact Brett Kipling on (08) 9841 8244

Karawara Community Project in Perth, Western Australia is seeking to identify earlier, and manage more effectively, the serious mental illnesses within their community. ***Jamie Robson*** is running training sessions for staff from Karawara and other interested agencies, coordinating interagency meetings on referral strategies and planning a series of management and policy seminars. He is also developing a training package that will include information about Early Intervention, mental health issues and assessment and referral procedures. Sustainability will be achieved by working at the management and policy level within the agency and through extensive networking with related agencies.

Contact Jamie Robson on (08) 9450 3817

Hunter Mental Health Services & Department of Community Services in Newcastle, New South Wales are working collaboratively to reduce the occurrence of mental health problems in children who have a primary caregiver with a mental illness. ***Neil Bannerman*** has completed a three-hour training session with Department of Community Services staff and will run a similar session with Hunter Mental Health Services staff in the near future. The content of the session includes an overview of Early Intervention models and programs, discussion of the effects of parental illness on family functioning and specific information on mental disorders. Sustainability will be achieved by the development of an interdepartmental protocol and extensive networking with agencies also working with families in which a parent has a mental illness.

Contact Neil Bannerman on (02) 4924 6055

Child & Family Services in Launceston, Tasmania is seeking to address the needs of young people who have come to the Department as a result of notification, becoming a ward of the state or through the juvenile justice system. ***Annie Hughes*** has just recently been appointed to work full time on the placement. Annie has a background in social work, education and counselling and already has an extensive network of contacts within the mental health community in Tasmania. Her immediate tasks will be to review existing policy and procedures, assess staff skills and identify barriers and opportunities for reorientation to early intervention. Sustainability in this placement will be achieved by developing policies and procedures that promote an early intervention approach to service delivery.

Contact Annie Hughes on (02) 6336 2376

For further information on Stream II activities, call the 'mental health workers' direct or contact me via e-mail aohanlon@health.adelaide.edu.au or phone (08) 8204 6802.
Anne O'Hanlon, Senior Project Officer

AusEinet Stream III Commissions: Good Practice Guidelines

After lengthy negotiations with the Mental Health Branch and the Early Intervention Working Group, AusEinet has commissioned several clinical researchers to produce good practice guidelines for a range of disorders/contexts. For each, the task is to produce guidelines specifically focused on early intervention with children and young people. The commissions are:

ADHD	Professor Philip Hazell
Anxiety Disorders	Professor Mark Dadds
Chronic Illness	Dr. Ken Nunn
Conduct Disorder	Assoc. Professor Matt Sanders
Delinquency	Mr. Lloyd Owen
Depression	Assoc. Professor Graham Martin

Graham Martin from AusEinet is currently working on a review of early intervention in Depression and will produce the guidelines without additional funding. The guidelines should be completed in April / May 1999 and will then be made available to the network as soon as possible.

For further information on Stream III commissions, contact me via e-mail aohanlon@health.adelaide.edu.au or phone (08) 8204 6802.
Anne O'Hanlon, Senior Project Officer

Funded under the National Mental Health Strategy by the Commonwealth Department of Health and Family Services

3rd National Human Services Conference for Regional Australia, Broken Hill, November 1998

The Third National Conference for Regional Australia held at Broken Hill on 20-21 November 1998 concluded with delegates endorsing a series of resolutions calling for action on recognition of the serious issues facing rural, remote and regional Australia. Conference Convenor, Barry Fowler, said that the one hundred and fifty delegates discussed a wide range of social, economic, cultural and environmental issues, adding:

> *The most important resolution recognised that expenditure on human services such as education, health and social security is an investment in rural, remote and regional communities benefiting the whole nation. This should not be seen by governments as a cost.*

Other Resolutions from the Conference were as follows:

Resolution 1 - That this conference recognises expenditure on human services such as education, health and social security as a social investment in rural, remote and regional communities benefiting the whole nation, not as a cost to government and calls on all levels of government to endorse, promote and support this position.

Resolution 2 - this conference calls on government to ensure that community service obligations are delivered into rural, remote and regional Australia (for example gambling).

Resolution 3 - This conference endorses the recommendations determined by local communities reflected in the policies of organisations such as ACOSS, NCOSS, The Regional Communities Consultative Council - and calls on governments to implement these.

Resolution 4 - Based on examples of successful initiatives evidenced in the proceedings of this conference, government programs make available additional and ongoing funding to rural, remote and regional communities to fund similar initiatives.

Resolution 5 - This conference supports the House of Representatives Standing Committee on Community Affairs Report on Competitive Tendering in the Welfare Sector and calls on governments to halt the spread of competitive tendering in the human services sector until such time as the social impact of the process has been critically evaluated.

Resolution 6 - That copies of the Proceedings including the resolutions of this conference be sent to relevant peak organisations and governments and that those organisations and governments be invited to comment and respond on progress and implementation in order to inform the 4th National Regional Australia Conference organisers and, that this feedback be made available to the 2nd Broken Hill Human Services Conference Organising Committee.

AusEinet contributed to the conference, providing information on how the Australian Early Intervention network could assist with dissemination of information on children and young people's mental health issues to rural health and mental health workers.

EINET

Have you subscribed to the AusEinet early intervention email mailing list? To subscribe, please email majordomo@auseinet.flinders.edu.au In the text, write "subscribe einet" in the mail message body.

AusEinet Database

The AusEinet database is steadily developing. To assist us please complete the following details and forward to AusEinet if you would like to be informed of future AusEinet activities, nationally or in your own State or Territory.

Please let us know if we have incorrect address details.

Name: .....

Organisation: .....

Address: .....

.....P/C.....

Telephone:.....Facsimile:.....

Email: .....

Return to AusEinet C/- CAMHS, Flinders Medical Centre, Bedford Park SA 5042. Telephone: 08 8357 5788 Facsimile: 08 8357 5484 Email: auseinet@flinders.edu.au

THE NEXT ISSUE WILL BE PRODUCED IN MARCH. DEADLINE FOR MATERIAL WILL BE FRIDAY 5TH MARCH 1999. PLEASE LET US KNOW WHAT YOU ARE DOING. CONTACT AUSEINET WITH SUGGESTIONS FOR TOPICS TO BE COVERED. AUSEINET WEBSITE ADDRESS http://auseinet.flinders.edu.au

This issue will be an expanded issue containing guest editorials on youth suicide, infant mental health and indigenous issues respectively, the evaluation of the first stocktake report and a discussion on consumer involvement in early intervention programs. We would be particularly appreciative of contributions from consumers/carers

Funded under the National Mental Health Strategy by the Commonwealth Department of Health and Family Services